CLIENT INFORMATION FORM *All fields are required.*

Date:	**Which Therapist Will You Be Seeing?**	**Who else will be in session today/future sessions with you?**

PERSONAL INFORMATION

Name:	First:	M.I.	Last:	Preferred:

Age:	Birth date:	Identify as: Male / Female / Non-Binary / Prefer not to answer / Other:

Address:	City:	State:	Zip:
Preferred Phone:	Email:		

Relationship Status: Single, not in a relationship / In a relationship / Living together / Engaged / Married / Estranged / Divorced/Annulled / Widowed

Occupation:	Employer:

Religious Affiliation: None / Protestant / Catholic / Jewish / Mormon / Orthodox / Muslim / Hindu / Buddhist / Atheist / Agnostic / Other:

Race/Ethnicity: Black/African-American / Asian / Hispanic/Latino / American Indian / Alaska Native Pacific Islander / Hawaii Native / White/Caucasian / Other:

Previous/Current Medical Diagnoses (from physician):

Any self-diagnosed chronic illness and/or disabilities?

Prescribed and OTC Medication (specify if not compliant):

Are you currently, or have you previously, seen any other counseling professional? If yes, please name and specify if current or previous:

PERSON RESPONSIBLE FOR PAYMENT

Person Responsible for payment:	Phone No.:	Email Address of person responsible for payment (if not SELF):

NOTE: This person will have to agree to our payment policy in order to charge them for your sessions. If they do not have that on file, you will be responsible for any payments due. We will need to contact this person to confirm payment responsibility (INITIAL HERE:_____)

PAYMENT POLICY (REQUIRED)

I understand that I am ultimately financially responsible for any balance. Houston Relationship Therapy does not bill to any third party payers nor will we provide any information other than receipts of payment made by you to you should you decide to seek reimbursement for our services. We will obtain payment at the time of service or in the case of a late cancellation or no-show.

Signature:	**NOTE:** You will be charged for sessions after your initial session not canceled with 24 hours' notice.

REFUND AND CANCELLATION POLICY (REQUIRED)

REFUND POLICY: Sign your name to confirm you understand that if you have purchased a pre-paid counseling package and choose to discontinue therapy, you may receive a 50% refund of the discounted amount you paid for any unused pre-paid therapy sessions. All pre-paid services have an expiration date of 1 calendar year from the date of purchase.	Signature:
CANCELLATION POLICY: Sign your name to confirm that you agree to being charged the full session fee if you do not give our office greater than 24 hours' notice should you choose to reschedule or cancel your appointment. The office will charge the credit card on file. In case of a missed couples session, both parties will be charged half of the total session fee. This confirmation will be used in case of a credit card dispute.	Signature:

This is a strictly confidential patient medical record. Rediscloure or transfer is expressly prohibited by law.

1.800.913.9613 * www.HoustonRelationshipTherapy.com * info@houstonrelationshiptherapy.com
Mailing Address: 1302 N. Shepherd Drive, 3rd Floor, Houston, TX 77008

HOUSTON Relationship Therapy

ADDITIONAL INFORMATION			
How did you hear about us? (Please be specific: Search Engine, Search Terms, Friend, Magazine, TV show, Event, Radio Commercial, etc.):			
If referral is from an HRT client, please include their name so they may get $10 off their hourly rate:			
If referral is from an HRT therapist, who?			
If referral is a physician:	Name:	Phone:	Okay to Say Thanks for referring You? Yes or No

IN CASE OF EMERGENCY		
NOTE: We will only contact this individual with your consent or wihout your consent should there be a threat to your physical safety. We may also choose to call upon 911 Emergency Services and all costs incurred will be your responsibility.		
Name:	Relationship to Client:	Phone:

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