

Danny Boylan LPC LLC

Client Information Form

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

May I leave you voicemails and emails at the above destinations in regards to appointments? _____

May I text you in regards to appointments? _____

Referred by: _____

- May I have your permission to thank this person for the referral?

Yes No

- If referred by another clinician, would you like for us to communicate with one another?

Yes No

Person(s) to notify in case of any emergency: _____

Name

Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (your signature): _____

Please briefly describe your presenting concern(s): _____

What are your goals for therapy? _____

Are you currently struggling with any suicidal thoughts? _____

Although you may choose to pay for sessions however you like (card, cash, check), I require that a credit or debit card be left on file for payment of any late cancellation fees. As explained in the informed consent document, a late cancellation fee/missed appointment fee of \$125 will be charged any time you provide less than 24 hours' notice to cancel or don't show up for an appointment. Please provide the following: (you may provide this either in person on your first visit or over the phone if you prefer)

Name on card: _____

Card number (I do not accept AMEX): _____

Address on file with card: _____

CCV code: _____

Expiration date: _____