

CLIENT INFORMATION

LEGAL  
NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
PREFERRED  
NAME \_\_\_\_\_ PRONOUNS \_\_\_\_\_  
RELATIONSHIP NUMBER  
STATUS \_\_\_\_\_ OF YRS/MTHS \_\_\_\_\_  
ADDRESS \_\_\_\_\_ SOC.SEC.# \_\_\_\_\_  
\_\_\_\_\_ HOME PHONE \_\_\_\_\_

REFERRED BY \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
EDUCATION EMPLOYER  
LEVEL \_\_\_\_\_ OR SCHOOL \_\_\_\_\_  
POSITION  
AND # OF YEARS \_\_\_\_\_  
WORK OR SCHOOL  
ADDRESS \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
PERSON RESPONSIBLE RELATIONSHIP TO  
FOR BILLS \_\_\_\_\_ RESPONSIBLE PARTY \_\_\_\_\_  
HEALTH CONCERNS  
& MEDICATIONS \_\_\_\_\_  
EMERGENCY RELATIONSHIP TO  
CONTACT PERSON \_\_\_\_\_ EMERGENCY CONTACT \_\_\_\_\_  
PHONE #'s FOR  
EMERGENCY: HOME \_\_\_\_\_ WORK \_\_\_\_\_

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I hereby authorize Dr. Ren Massey to provide psychological services to myself and/or the minor in my custody.

\_\_\_\_\_  
NAME SIGNATURE DATE

I agree that I, or the agency I represent, am responsible for bills and not my insurance company.

\_\_\_\_\_  
NAME SIGNATURE DATE

I HAVE BEEN INFORMED THAT I AM RESPONSIBLE FOR FEES FOR SESSIONS NOT CANCELED 48 HOURS IN ADVANCE.

\_\_\_\_\_  
NAME SIGNATURE DATE