Registration/Consent

Full Name(Include middle initial):_____ SS#:_____

Address:_____

City:_____ Zip code:_____ Age:_____ Gender:_____

Date of Birth:_____ Cell Phone #_____

Secondary Phone #_____

Email_____

Address:_____

Insurance Information Insurance Company:_____

Policy Holder's Name:_____ Relation to Client:_____

Policy Holder's Date of Birth:_____ Policy Holder's Address (if different from above)

_____ Policy Holder's Phone #_____

Policy Holder's SS #_____ ID#_____ Group#_____

Person responsible for payment:_____

Who referred you:_____ Please describe the current challenges that have caused you to seek counseling, consultation, and / or evaluation:

_____

_____

_____

I request counseling, consultation, and evaluation with Matt McTeague, LISW. I have read and understand the Information and Consent document detailing these services.

Signed:_____Date:_____ (Client signature)

Signed:_____Date:_____ (Parent or Guardian if client is a minor)

Signed:_____Date:_____

(Witness)