Cheryl Warner, Ph.D.
Licensed Counseling Psychologist

Client Information

Consent for Services

General Client Information:		
Client's Name:		*Date of Birth:*
Parent/Guardian's Name (if client is a minor)		
Address of Residence:		
City:	*State:*	*Zip:*
Mailing Address (if different from above):		
City:	*State:*	*Zip:*
Home Phone: ( )		*Best Time to call:*
Work Phone: ( )		*Best Time to call:*
Cell or Page Phone: ( )		*Best Time to call*
Spouse / Partner's Name:		*Spouse / Partner's Phone: ( )*
Please complete the below if employed and/or will be using health insurance for the services provided.		
Insured Name & Address:		*Insured Date of Birth:*
Employer:		*SSN:*
Insured (circle) Y N	*Insurance Company:*	
Policy Number:	*Insurance Company Phone:*	
Emergency Contact Information:		
Name:		*Phone: ( )*
Relationship to Client:		
Who will be responsible for the payment (including copayments) of the services?:		
Name:		
Phone:		
Relationship to client:		

Client's Signature _____ Date _____

Parent / Guardian Signature _____ Date _____