Client Information Update Form

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720-279-4631

Your Counselor: _____

Today's Date: _____

GENERAL INFORMATION

Full Name: _____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev.

Name you prefer: _____ Date of Birth: _____

CONTACT INFORMATION

Mailing Address: _____

City: _____ State: _____ Zip Code : _____

May we send mail here: ☐ Yes ☐ No

Home Address (if different): _____

City: _____ State: _____ Zip Code : _____

May we send mail here: ☐ Yes ☐ No

Home Phone: (_____) _____ May we leave a message here: ☐ Yes ☐ No

Cell Phone: (_____)_____ May we leave a message here: ☐ Yes ☐ No

Work Phone: (_____) _____ May we leave a message here: ☐ Yes ☐ No

Email Address: _____ May we send a message here: ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

TERMS OF SERVICE

I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.

Signed: _____ Date: _____

All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.

Credit Card Number: _____ Exp. Date: _____

Billing Zip Code: _____ Type of Card: ☐ AMEX ☐ VISA ☐ MC