Authorization for Treatment

Christine Hardway, LCSW

CLIENT INFORMATION

(Please print legibly.)

Name:_____
Address:_____City:_____State:____Zip:_____
Phone(Hm): _____ Wk:_____Cell:_____
Date of Birth:_____ Age:_____Email: _____
Marital Status: Single Married/Partnered Divorce Widowed Separated
Employer: _____Occupation:_____
Primary Physician:_____ Phone:_____
List any significant health problems: _____
_____
List any medications you are taking and the dosage:_____
_____
Emergency Contact: _____ Phone :_____
Relationship to emergency contact: _____ _____
How did you hear about Christine Hardway, LCSW? _____

Reason for seeking treatment at this time: _____

Informed Consent

I consent to receive counseling/therapy from Christine Hardway, LCSW. I understand that therapy requires mutual effort on the part of both the client and the therapist. There are no guarantees that I will feel better. I acknowledge that I have received a copy of Christine Hardway, LCSW's Policies and Procedures. I understand that 24-hour notice is required to cancel an appointment or I will be responsible for paying a fee for the space reserved.

Signature: _____ Date:_____

For EAP (Employee Assistance Program) clients only:

Release of Information:

I authorize the release of any information necessary to process my claim.

Signature: _____ Date:_____