

Patricia Tricia Flacher, MA, LPC, LMHC
Licensed Mental Health Counselor

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Client Information

Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthplace: City/ State/ Country _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

(Please check best number to leave message)

Email: _____ Would you like reminder messages via email? Y N

Would you like to be added to our email list to receive updates about our services and therapy groups? Y N

Gender: (M/F) _____ Date of Birth: _____ Social Security No: _____

Referred by: _____ Phone: _____

May I thank this individual for the referral? (Please Initial) Yes: _____ No: _____

Responsible Party Information (IF OTHER THAN CLIENT)

Relationship: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer Information

Employer: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Please complete the other side of this form

The self-pay fee for psychotherapy, initial consultation is \$225.00. All following visits are \$160.00.

I have reviewed the Introduction to Psychotherapy and Financial Agreement information, and I voluntarily agree to participate in psychotherapy services.

Print name

Signature of client or responsible party

Date