

Neophytos (Neo) Papaneophytou PhD
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<https://drneo.us/>

Client Identification

Name _____ D.O.B. / Age _____

Address: _____

Cell Phone: _____ Email: _____

Work Phone: _____

Referral source _____ Phone: _____

Services Requested:

Consent for Service

I (Print name) _____, being of age 14 or over, understand that the above services have been requested by me. If I am under age 18, requested by my parents/ guardians on my behalf. Services will be rendered by the clinician (Dr. Neo Papaneophytou). I understand that I may ask any questions about these services, that I have the right to be fully informed, and I have the right to refuse services.

(Signature of Client)

(Date)

(Signature of Parent/ Guardian if Client is a minor)

(Date)

(Signature of Witness)

(Date)