Jennifer Snow, MS, LPC, PLLC
13740 Research Blvd. Bld. K, Ste. 2 - Austin, TX 78750
(512) 786-7466

ADULT INFORMATION SHEET

NAME:_____DATE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____

EMAIL: _____

BIRTH DATE:_______________ AGE:_____

OCCUPATION:_____HOW LONG:_____

PLACE OF EMPLOYMENT:_____ EDUCATION:_____

ADDRESS:_____PHONE:_____

CITY:_____STATE:_____ZIP:_____

IS IT OKAY TO LEAVE A MESSAGE AT THE NUMBERS PROVIDED? YES NO

IS IT OKAY TO EMAIL YOU? YES NO_____

SPOUSE / SIGNIFICANT OTHER

NAME:_____BIRTH DATE:____________AGE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____

EMAIL: _____

PLACE OF EMPLOYMENT:_____

WORK PHONE:_____EDUCATION:_____

MARITAL STATUS:_____YRS._____LENGTH OF RELATIONSHIP_____

CHILDREN **BIRTH DATE** **AGE** **SEX** **GRADE**

PRIMARY CARE PHYSICIAN:_____

MEDICATION (INCLD. DOSAGE) & NAME OF PRESCRIBING DOCTOR:

MEDICAL CONDITIONS OR DIAGNOSIS:_____

PREVIOUS THERAPY, BRIEF REASON FOR TREATMENT AND TERMINATION:

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME:_____**HOME PHONE:**_____

ADDRESS:_____

CITY:_____**STATE:**_____**ZIP:**_____

CELL PHONE:_____**WORK PHONE:**_____

RELATIONSHIP:_____

I WAS REFERRED BY: _____

BRIEF DESCRIPTION OF PRESENTING ISSUE:

I AGREE TO BE RESPONSIBLE FOR ALL FEE'S INCURRED BY ME OR ON MY BEHALF FOR SERVICES RENDERED BY JENNIFER SNOW, MS, LPC. I UNDERSTAND THAT PAYMENT FOR SERVICES ARE DUE WHEN RENDERED.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE INFORMED CONSENT \ INFORMATION SHEET CITING THE PROCEDURES, SESSIONS, PRIVACY RULES, FEES, INSURANCE AND REFERRALS AS STANDARD POLICY AND I AGREE TO THE TERMS SET OUT THEREIN. I UNDERSTAND THAT IF A SUIT IS FILED TO COLLECT ANY UNPAID BALANCE ON MY ACOUNT, I AGREE TO PAY THE REASONABLE ATTORNEY'S FEES FOR SUCH PROCEDURES AND I AGREE VENUE IS ACCEPTABLE IN TRAVIS, COUNTY, TEXAS

_____ _____

PATIENT SIGNATURE **DATE**
CONSERVATOR, OR
PARENT

Acknowledgment of Receipt of Informed Consent

By engaging in the counseling process, I understand and commit to the activities and policies outlined in the Informed Consent. By signing below, I affirm that I have read and understand the information provided. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and my responsibility as a client. I also understand that the results of counseling can be variable and that the attainment of a positive outcome is dependent upon the effort expended by both myself and my counselor.

If you have any further concerns or questions that I have not addressed, please feel free to discuss them with me in our session. Thank you.

Please sign and date below stating that you have read and understand this document. I look forward to our journey together.

Client/ Parent or Guardian's Printed Name **Date**

Client/ Parent or Guardian's Signature **Date**

I have discussed the above issues and policies with the client. My observations of this person's behavior and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent to treatment.

Therapist Signature **Date**