

# NEW VISION COUNSELING

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

## Preferred Method of Contact

We may need to contact you outside of your scheduled appointment time. Please, check each and every option you would prefer. You may update this form at any time with our office staff during business hours.

### Cell Phone:

\_\_\_\_\_ Leave a detailed message on my voicemail.

\_\_\_\_\_ Leave only a call-back name and phone number on my voicemail.

\_\_\_\_\_ **Do not** leave any type of voicemail or text message on my cell phone.

### The office staff is unable to text you. If you and your clinician agree to texting, please check one box below:

\_\_\_\_\_ Leave a detailed message by my text message.

\_\_\_\_\_ Leave only a call-back name and phone number in the text message

### Home Phone:

\_\_\_\_\_ Leave a detailed message on my answering machine or with anyone answering

\_\_\_\_\_ Leave only a call-back name and phone number on my answering machine or with any person answering the phone if I am not there.

\_\_\_\_\_ **Do not** leave a message or call-back information with anyone if I am not there.

### Work Phone:

\_\_\_\_\_ Leave a detailed message on my voicemail, the main voicemail, or with any employee answering

\_\_\_\_\_ Leave only a call-back name and phone number on my voicemail, the main vm, or any employee

\_\_\_\_\_ Do not leave any type of message or call back information if I am not there.

### Email: (unencrypted)

\_\_\_\_\_ Email any information to this email address only: \_\_\_\_\_

### **You may discuss the following with any individual I have listed below:**

\_\_\_\_\_ Medication management      \_\_\_\_\_ Counseling      \_\_\_\_\_ Billing      \_\_\_\_\_ Schedule

Name	Relationship	Phone Number

\_\_\_\_\_  
Signature of Client or Client's Qualified Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Qualified Personal Representative