**Confidential Solution**

Elaine Stevens, Ph.D.

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704-281-3001

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New Client Form

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

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M\_\_\_\_\_ F\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_ Marital Status: S\_\_\_\_M\_\_\_\_D\_\_\_\_W\_\_\_\_

Spouse’s Name (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Dr. Elaine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your main reason for acquiring Dr. Elaine’s consultation services?

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**Please read the following Statement and Consent Information. Sign, Date & Email to drelaine@drelainestevens.com**

**Confidentiality Statement**

I, the undersigned, understand that all sessions with Dr. Elaine Stevens are held in the strictest of confidence. Dr. Elaine Stevens will not reveal any information discussed during any of the sessions with anyone. Should you choose to discuss any part of the session, that is your right, for it is your information to share as you wish. The only exception to this rule is if Dr. Stevens foresees any life threatening situations OR if your records are subpoenaed by law.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Consulting Services and Financial Responsibility**

I, the undersigned, hereby give Dr. Elaine Stevens permission to consult with me concerning my relationship issues. I understand that Dr. Elaine Stevens will not be responsible for any adverse behavior or choices made by myself as a result of consultation services. I agree to pay all charges in full at the time of service, unless prior arrangements have been made. I also understand that if I need to cancel an appointment, I must do so at least 24 hours before the date of the appointment to avoid any charges.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_