Pete McClintock M.A., MFT

License # MFC27356

Date:_____

INTAKE FORM

CLIENT INFORMATION

Name:_____Referred By:_____

Home Address:_____Zip Code:_____

Phone Numbers:(home)_____(work)_____(cell)_____

Social Security Number:_____Date Of Birth:_____Age:_____

Occupation:_____Employer:_____

Previous Psychotherapy: Yes_____ No_____ Provider:_____

RESPONSIBLE PARTY (IF CLIENT IS A MINOR)

Name:_____Relationship:_____

Home Address:_____Zip Code:_____

Phone Numbers:(home)_____(work)_____(cell)_____

Marital Status:_____Family Members Present:_____

Occupation:_____Employer:_____

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY AGREEMENT

I consent to psychotherapeutic procedures, treatment and services rendered to myself (or the client , if a minor) by Pete McClintock M.A., MFT. I understand that all information disclosed within sessions is confidential except with regards to child abuse, elder abuse, as mandated by law or where the client presents a danger to himself or others. I am responsible for scheduled appointments which are not cancelled 24 hours before the time of appointment and I understand I may be charged the entire session fee. I assume responsibility for all charges rendered for me or the client's treatment.

The agreed upon fee agreement is as follows: Individual $_____Family $_____Couple $_____

_____ _____

Client/Guardian Therapist