19 East Abarr Drive~Pueblo West, CO 81007
435-817-0155

Clive R. Hallam-LMFT, MBA
Licensed Marriage and Family Therapist, CO-0001268, UT-8971102-3902 and WY-134

My Therapy Matters Clinicians: Clive Hallam; Bradley Thorsen; Adam Jeffryes;; Shannon McShane; Robert Bundy; Scott Simpson; Laura Reinert

Client Registration

Name:_____ Date:_____

Street Address:_____ City:_____ State:___ Zip_____

Phone Numbers: Home:_____ Cell:_____ Work:_____

May I text you general appointment information? Yes/No: Signature authorizing texts_____

May I leave voice messages at the numbers listed above? Yes/No

Email address:_____

Date of Birth:_____ Age:_____ Gender:_____

Occupation:_____ Employer:_____

Household Annual Income:_____ Highest Education Completed:_____

Client SSN#_____

Insurance Provider:_____ Policy Number:_____

Co-Pay amount:_____

Primary Care Provider:_____

Referral Source or how your heard about My Therapy Matters:_____

Reason(s) for seeking clinical services? _____

_____

_____

Have you received previous mental health treatment? Yes/No. If yes, when, where, with whom and was it helpful?_____
_____

Allergies?_____

Current Medications or Medical Issues?_____
_____

Advanced Directives?_____

Highest Education Achieved?_____

Educational Concerns?_____

Family History of Mental Illness?_____

Social or Occupational Concerns?_____
_____

Family or Relationship Concerns?_____
_____

Legal Issues?_____

Financial Issues?_____

Substance Abuse Issues?_____

Are you currently having suicidal thoughts?_____

Have you had suicidal thoughts in the past? If so, when:_____

Are you currently having homicidal thoughts?_____

Do you currently feel threatened or in danger of being harmed?_____

What have you tried in the past to resolve current issues or concerns? _____
_____

What are your strengths and/or motivation for treatment?_____
_____

Current hobbies/interests?_____

_____

What else would you like me to know at this time?_____

Emergency Contact Information:

Name:_____ Relationship:_____

Contact Number:_____

Authorization to Release Medical Information and Financial Agreement

I authorize the release of protected health information to my primary care provider and insurance company for the purpose of coordination of care and to process my insurance claims.

The undersigned hereby agrees that in consideration of rendered services, the client or legal guardian individually, jointly, and severally obligates him/herself or themselves to pay the account of Clive Hallam, LMFT with My Therapy Matters. The agreed upon fees are as stated on the summary of benefits or charges given to me this day. I understand that financial obligation is my/our responsibility as the client/guardian and should the insurance company deny any payment or I/we default on payment arrangements the undersigned agrees to pay reasonable attorney fees and collection expenses should the account be referred to a third party for collection.

_____ _____

Client/Parent (or Guardian) Signature Date

_____ _____

Clinician Signature Date