River Bend Counseling

Marnee Alfson, MA, LMHCA

CONFIDENTIAL CONTACT INFORMATION

The following information will help us get to know you. Please fill out this form and bring it to your first session.

_____ _____ _____
Client's Last Name First Name Middle Initial

_____ _____ Gender: _____
Date of Birth Age

_____
Address: Number and Street

_____
City State Zip

Preferred Telephone Contact Number: _____

Emergency Contact: _____ _____
Name Phone

Referred by: _____

PERSON RESPONSIBLE FOR PAYMENT if other than the client

_____
Parent/Guardian Last Name First Name Middle Initial

_____
Date of Birth Relationship to Client

_____
Address: Number and Street

_____
City State Zip

I hereby request to receive communications regarding my protected health information, other than information given to me
*in person, as follows (**INITIAL** ALL METHODS PERMISSIBLE):*

_____ U.S. Mail at address: (same as above? ____) or: _____
_____ Telephone: (same as above? ____) or: _____
_____ Voice Mail messages at: _____
_____ Other at: _____
_____ DO NOT CONTACT ME BY: _____
If the restrictions affect my payment arrangements, payment will be made as follows:_____
_____

I authorize the above initialed communication methods. I understand that RIVERBEND COUNSELING will collaborate with all reasonable requests for alternative communications, but may not be able to so if I do not provide a clear method of contact, or if I do not provide information regarding how payment will be made, or there are technical difficulties or at the RIVERBEND COUNSELING'S staff discretion. I understand that RIVERBEND COUNSELING CANNOT GUARANTEE THE CONFIDENTIALITY of any of above listed methods of communication.

_____ _____
Signature of Client Date

_____ _____
Signature of Client's Parent / Guardian / Personal Representative Date

For Office Use Only:

_____ _____ Individual Couple Family Group
Date of Term Counselor

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