THE SUMMIT COUNSELING CENTER

CLIENT INFORMATION AND CLIENT CONSENT FOR TREATMENT

COMPLETE FULLY AND RETURN TO FRONT DESK. PLEASE PRINT. ***Date:*** _____

Client's Name: _____
Last ***First*** ***Middle***

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____**Work Phone:** _____**Cell Phone:** _____

Which phone number is preferred for appointment reminder calls? ☐ Home ☐ Work ☐ Cell

Sex: M F **Marital Status** *(circle one)* Minor Single Married Divorced Widowed

Date of Birth: _____ **Age:** ____ **Email Address:** _____

____ I would like to receive periodic emails from The Summit regarding, programs, groups, and classes.

How did you hear about The Summit? _____

Place of worship, if any: _____

Client (or Parent) Employer: _____

If Minor, School / Grade: _____

SPOUSE / PARENT / GUARDIAN

Name: _____

Phone: _____

Relationship: _____

IN CASE OF EMERGENCY, NOTIFY:

Name: _____

Phone: _____

Relationship: _____

- I understand that I am responsible for complete payment of all services when rendered.
- I have received, read, understand, and agree to The Summit's Consent to Treatment Agreement, Standard Fee Information, Client Rights and Responsibilities, and HIPAA Privacy Policy.
- I give full consent for evaluation and treatment until I otherwise notify The Summit Counseling Center.
- I am the parent/legal guardian and have legal responsibility for the above-named minor child.

- **I am aware of the 24-hour cancellation policy and know that failure to adhere to this policy will result in a full session fee charge of up to $120 for all clients, even those receiving assistance.**

Client/Parent/Legal Guardian Signature _____ **Date**_____

**********OFFICE USE ONLY**********

Information checked in PA: Date: _____ By: _____