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:** _____

Date of Birth: _____ **Age:** ____ **Sex:** M F

Marital Status: ☐Single ☐Married ☐Partnered ☐Divorced ☐Legally Separated ☐Widowed

Ethnicity/Race:

☐Native American ☐Asian ☐Black/African American ☐Hispanic ☐Pacific Islander ☐White

Email address: _____

☐ **Yes** ☐ **No** I would like to receive periodic emails regarding Summit programs, groups, and classes.

How would you like to receive your upcoming appointment notification:
☐ Home Phone ☐ Work Phone ☐ Cell Phone **Call** ☐ Cell Phone **Text** ☐ email

How did you hear about The Summit? _____

Place of worship, if any: _____

Client (or Parent) Employer: _____

If Minor, School / Graduation Year: _____

If Minor, please include contact information for BOTH Parents/Guardians.

IN CASE OF EMERGENCY/PARENT

Name: _____
Phone: _____
Relationship: _____

PARENT:

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 and Service 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 for all clients, even those receiving assistance.**

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

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

Information checked in Valant: Date: _____ By: _____