Matthews Counseling, LLC
Chester Springs, PA

Client Information

Today's Date: _____

Client Name: _____ Date of Birth: _____

Home Address: _____

_____

Is it ok to send mail? (if necessary for statements, billing, etc): Y N

Client Cell Phone: _____ Ok to call? Y N Ok to text? Y N

Client E-mail: _____ Ok to e-mail: Y N

Parent/Guardian Cell Phone (if applicable): _____

Ok to call? Y N Ok to text? Y N

Parent/Guardian E-mail:_____ Ok to e-mail: Y N

How did you find out about the therapist or practice? _____

By signing this form, I indicate that the above is correct, and staff of Matthews Counseling may contact me via the methods above (if indicated) for scheduling, billing, or other purposes in the provision of services. **Staff will not communicate with anyone else regarding you or your family member without you signing an appropriate release of information form.**

Client Name (Print): _____ Client Signature: _____

Parent/Guardian Printed Name(s) (if applicable): _____

_____

Parent/Guardian Signature(s) (if applicable): _____

_____