Matthews Counseling, LLC
Chester Springs, PA

EMERGENCY CONTACTS

Please list <u>at least one</u> person who you will authorize your provider to contact in the event of a medical or clinical emergency. *Our providers cannot meet with you without having at least one emergency contact on file.*

Name: _____

Phone number: _____

Relationship to client: _____

Name: _____

Phone number: _____

Relationship to client: _____

I attest that this information is complete and accurate. I understand that only in the event of an emergency would this contact be made.

Date: _____ Client/Parent/Guardian: _____