



Today's Date: _____

face sheet client # _____

Personal Information	
First Name: _____ MI: _____ Last Name: _____	
Marital Status: _____	
Street Address: _____	Date of Birth: _____
	Age: _____
City, State, Zip Code: _____	Cell Phone: _____
Employer: _____	SSN: _____
Email Address: _____	

Billing Information	
Responsible Party (the person who will be paying the per-session fee): ___same as above. Name _____	
Street Address: _____	Work Phone: _____
City, State, Zip Code: _____	Mobile Phone: _____
Relationship to Patient: _____	
Your signature indicates that you agree to be responsible for fees and charges. Signature: _____	

To be completed by Counselor:

PCP: _____	DX Codes: _____
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