relate center

relatecenter.com 512-327-3723
3160 Bee Cave Road, Suite #300, Austin Texas 78746

Client Information Form

Today's Date: ....

PATIENT INFORMATION

Last Name .... First .... Middle ....

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Marital Status
☐ Single, never married
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Date of Birth .... Age .... Sex ☐ M ☐ F Referred by ....

Street Address .... Primary Phone ☐ H ☐ W ☐ M ....

City .... State .... ZIP Code .... Alternate Phone ☐ H ☐ W ☐ M ....

Email Address .... Email reminders ☐ Y ☐ N

NOTE: Appointment reminders are sent as a courtesy. 24 hours notice is required for appointment cancellations. If you are unable to provide 24 hours, you will be responsible for the session fee.

Occupation: .... Employer .... Employer's Phone No. ....

PARTNER/SPOUSE INFORMATION *(if applicable)*

Last Name .... First .... Middle ....

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Marital Status
☐ Single, never married
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Date of Birth .... Age .... Sex ☐ M ☐ F

Street Address .... Primary Phone ☐ H ☐ W ☐ M ....

City .... State .... ZIP Code .... Alternate Phone ☐ H ☐ W ☐ M ....

Email Address: .... Email reminders ☐ Y ☐ N

NOTE: Appointment reminders are sent as a courtesy. 24 hours notice is required for appointment cancellations. If you are unable to provide 24 hours, you will be responsible for the session fee.

Occupation: .... Employer .... Employer's Phone No. ....

EMERGENCY CONTACT INFORMATION

Name of local friend or relative: .... Relationship .... Primary Phone ☐ H ☐ W ☐ M .... Alternate Phone ☐ H ☐ W ☐ M ....

RESPONSIBLE PARTY

Name (please print): .... Address (if different) ....

PAYMENT IS REQUIRED AT THE TIME OF SERVICE: All professional services rendered are charged directly to the patient and each patient is responsible for the payment fees. Services are not rendered on the basis insurance will pay all fees. Any financial concerns should be discussed with the Therapist.

I HAVE READ THE ABOVE STATEMENT AND AGREE TO BE PERSONALLY RESPONSIBLE FOR ALL CHARGES AND FEES. ADDITIONALLY, I GIVE MY CONSENT FOR TREATMENT.

In agreement

Patient Signature	Date	Partner/Spouse Signature (if applicable)	Date