

Contact Information

Client name:		DOB:	Schoo	l:	GR:	
Name of person completing for	m:		Relationship to	client:		
Address:		City:	State	e: Zip	:	
Best number:	Second number:		Email:			
Other parent / guardian name i	f applicable:		Cu	stody: joint	standard ot	her
Second Address:		City:	State:	Zip:		
Best phone:	Email:					
How did you hear about Austin	Therapy for Girls?					
		Paymen	t Information			
on file. Your information is con Person responsible for payment I, (those of my child) and to keep for all sessions. Name on CC:	:, autho my credit card numbe	Preprize ATFG to cher on file for fut	eferred method of arge my credit ca ure use. Group pa	f payment: ord for paymory will be	cash check cent of my sessone charge at the	ion fees ne end of the month
Exp:CV num	ber: Billing	g address:				
City:	State	e:	Zip:			
Client / parent signature:				_ Date:		
E Current Phy	MEDICAL INg patterns: □ normating patterns: □ Institution	al/no concern normal/no co	ncern 🗆 not ei	n sleep nough	□ too much s □ too much	•
	ME		(circle all that a			
sad angry	anxious hyper	unable to f	ocus worried	extreme	ups/downs	distant
tearful he	elpless hopeless	negative at	titude power	struggles	avoidant	irritable
I have read fully and received social media policy, privacy programment for my minor child/adolescent	olicy(on website), pant or myself and have	ayment inform e the legal righ	nation and 24 ho	our cancella treatment.	ation policy. I	-
Client/Legal Guardian:		D	A1E:			_