ANNA RHODES M.A. LM.H.C, L.M.F.T.A
❖
PSYCHOTHERAPY & CONSULTATION

INFORMATION SHEET

NAME _____

BIRTHDATE _____

ADDRESS _____

_____

TELEPHONE _____ _____ _____
HOME **OFFICE** **CELL**

E-MAIL ADDRESS _____

EMERGENCY CONTACTS: _____**Tele:**_____

_____**Tele:**_____

PRIMARY PHYSICIAN(S) _____

REFERRED BY _____

May I have your permission to thank them for referring you _____

CONSENT FOR TREATMENT/STATEMENT OF FINANCIAL

RESPONSIBILITY/RELEASE OF INFORMATION

I hereby give consent for psychological treatment. I agree to be financially responsible for all charges that may accrue from such treatment.
I accept Anna Rhodes, M.A., cancellation policy and authorize that Anna Rhodes, M.A. may release any information to the insurance company that is required for processing any claims. This authorization will remain in effect indefinitely.

SIGNATURE _____

DATE _____