KATE REYNOLDS, MA, LPCC

Welcome to Counseling Form

Date: _____

Names and ages of all persons who might receive counseling services:

Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work/ Cell Phone: _____

Name of Insurance policy holder:
Insurance number:
Group ID number:
Birthdate of policy holder:

Person to Contact in Case of Emergency (with Phone #):

How or Who referred you to counseling?

Previous and Current Therapy, Counseling, and/or Human Agency Assistance:

Please list any relevant medications**:**

Confidentiality Statement

The therapeutic services of Kate Reynolds, MA, LPCC are confidential. This means that I do not release any information to persons or agencies regarding the fact that you are receiving counseling nor the nature of your concerns without your written consent. Danger to self and/or others (i.e., suicide or homicide) may necessitate the breaking of confidentiality. In addition, by law I must report suspected child abuse and/or neglect communicated to us by you.

"I have read the above statement and understand my rights regarding confidentiality."

_____ _____

Date Signature of Client and Parent or Guardian