

CHARIS Counseling Associates
CONFIDENTIAL CONTACT INFORMATION (CHILD AND ADOLESCENT AGES 0-18)

The following information will help us get to know you. Please fill out this form and bring it to your first session.

Client Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____ Gender: _____

Address: _____ Number and Street _____

City _____ State _____ Zip _____

Preferred Telephone Contact Number: _____

Emergency Contact: _____ Name _____ phone _____

Referred by: _____

RESPONSIBLE PARTY – To be completed by the parent or guardian of minors

Name of parent/guardian (if under 18 years): Last Name _____ First Name _____ Middle Initial _____

Name of parent/guardian (if under 18 years): Last Name _____ First Name _____ Middle Initial _____

Parent's Marital Status (circle one): Never married Engaged Married Divorced Widowed Separated Living together Remarried

Parents/guardians Date of Birth _____ Relationship to Client _____

Address: _____ Number and Street _____

City _____ State _____ Zip _____

*I hereby request to receive communications regarding my protected health information, other than information given to me in person, as follows (**INITIAL ALL METHODS PERMISSIBLE**):*

_____ U.S. Mail at address: (same as above? _____) or: _____

_____ Telephone: (same as above? _____) or: _____

_____ Voice Mail messages at: _____

_____ Other at: _____

_____ DO NOT CONTACT ME BY: _____

If the restrictions affect my payment arrangements, payment will be made as follows: _____

I authorize the above initialed communication methods. I understand that CHARIS Counseling Associates will collaborate with all reasonable requests for alternative communications, but may not be able to so if I do not provide a clear method of contact, or if I do not provide information regarding how payment will be made, or there are technical difficulties or at the CHARIS' staff discretion. I understand that CHARIS CANNOT GUARANTEE THE CONFIDENTIALITY of any of above listed methods of communication.

Signature of Client _____ Date _____

Signature of Client's Parent / Guardian / Personal Representative _____ Date _____

For Office Use Only: _____
Date of Term _____ Counselor _____ Individual _____ Couple _____ Family _____ Group _____