CHARIS Counseling Associates
CONFIDENTIAL CONTACT INFORMATION (Adult)

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

Client's 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: ______

PERSON RESPONSIBLE FOR PAYMENT if other than the client

Parent/Guardian Last Name ______ First Name ______ Middle Initial ______

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