Julia Fazio, MA, LMFT

2306 Lake Austin Blvd | *Austin, Texas 78703* | *512.920.3347*

CONFIDENTIAL CLIENT INFORMATION

Name: ____ Date: _______________________

Address City / State / Zip: ____

____

Phone: _______________________ Email: ____

Occupation/ Employer: ____

Date of Birth: ___________________

Relationship Status: ____________________ How long? ________________________________

Name(s) of previous therapist(s) and dates seen: _______________________________________

____

Medical Doctor / Phone Number: ____

Emergency Contact (name / relationship / number): ____________________________________

Describe any health concerns or medications: ____

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How did you find me? Internet search ___ Friend____ Referred by: ________________________

Please list the names of your family members or important people in your life:

____

____

Please describe briefly the concern(s) that bring you here: ________________________________

____

____

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CONSENT FOR TREATMENT

Please initial to show your consent in the following areas:

_____ I hereby grant my permission to participate in counseling with Julia Fazio, and understand that therapy is a joint effort between Julia Fazio and myself, the results of which cannot be guaranteed.

_____ I agree to pay Julia Fazio for services in the amount of $100 per session for individual counseling or $115 per session for couples counseling upon receipt of services.

_____ I have read and understand Julia Fazio's policies regarding the use of electronic communications (text, email).

_____ I have read, understand, and agree to the office policies given to me. My initials here signify that I have been given the current office policies of Julia Fazio.

Client Signature: ____

Date: ______________________

Printed Full Name: ______________________________________