

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: _____

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 \$135 per session for individual counseling or \$160 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: _____