Julia Fazio, MA, LMFT

juliafazio.com | 512.920.3347

CONFIDENTIAL CLIENT INFORMATION

Name: ____ Date: _____________________

Address City / State / Zip: ____

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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:

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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 $165 per 50-minute session.

_____ **For cancellations made less than 24 hours prior to my appointment time, I understand that I will be charged the full fee for the missed session.**

_____ 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