Rachael Frankford Counselling

Client Information Form

Date: _____

1. **Name**:_____
   First *Last*

2. **Age**:_____ **Date of Birth**: _____

3. **Place of Birth**: _____

4. **Address:** _____

   _____

5. **Phone you would like to be reached at:** _____

6. **Marital/relationship Status:**_____

7. **Do you have children?** Yes ___ No ____ If yes, how many and what are the ages? _____

7. **Occupation:** _____

8. **Emergency Contact**: _____
   Name *Phone*

9. **Referred By:** _____

10. **Reason for Referral**:

    _____
    _____
    _____
    _____

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Limits to Confidentiality:

Your therapist is legally and ethically responsible to maintain confidentiality about any discussions that take place as part of therapy. No information can be released to third parties without your written consent. Exceptions may occur in cases of child abuse, or abuse of a disabled dependent adult, a court ordered subpoena, or where there is a clear and present danger to yourself or others or when there is disclosure of sex abuse by a health care professional.

I have read and understand the above statement and agree to the terms of confidentiality outlined in this form. **Client initials__**

Consent to Treatment:

During therapy sessions, you will be discussing with your therapist private topics involving your personal relationships. By signing this document, you agree and consent to this process. **Client initials___**

Financial Agreement:

I agree to be responsible for all therapy services received from Rachael Frankford MSW, RSW (including any claims rejected by my insurance company). I am aware that payment is due at the time of service. I understand I will be charged for appointments missed or cancelled with less than 48 hours notice. **Client initials ___**

Your signature below represents acceptance of all the terms on this form.

Client signature: _____ Date: _____