

Registration

Name: _____ (Include middle initial) SS#: _____
 Address: _____
 City: _____ Zip code: _____
 Age: _____ Gender: _____ Date of Birth: _____
 Cell Phone # _____ Secondary Phone # _____
 Email Address: _____
 If applicable, School name & Grade: _____

Insurance Information

Insurance Company: _____
 Policy Holder's Name: _____
 Relation to Client: _____
 Policy Holder's Date of Birth: _____
 Policy Holder's Address (if different from above) _____
 Policy Holder's Phone # _____ Policy Holder's SS # _____
 ID# _____ Group # _____

Person responsible for payment: _____
 Who referred you: _____
 May we have your permission to send thanks to this person or program without using your name: _____

Please describe the current challenges that have caused you to seek counseling, consultation, and / of evaluation: _____

I request counseling, consultation, and evaluation with Molly Fields PCC-S, LSW. I have read and understand the Information and Consent document detailing these services.

Signed: _____ Date: _____
 (Client signature)

Signed: _____ Date: _____
 (Parent or Guardian if client is a minor)

Signed: _____ Date: _____
 (Witness)