Client Information Sheet

Women's Solutions LLC
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610.866.6855
Jackie L. Gower, M.Ed., LPC

Client Information:
Name _____
Address _____
City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____
EMAIL _____ Date of Birth _____

Current Medications _____
Previous Dates of Counseling _____

Person to Contact in the event of an Emergency _____
Phone ( ) _____ Relationship to Client _____

Reason for Seeking Counseling:

Person responsible for Payment (if other than yourself**):** □ Check if information is same as above
Name _____
Address _____
City _____ State _____ Zip _____
Cell Phone ( ) _____ Work Phone ( ) _____
Date of Birth: _____ Relationship to the Client: _____

Contact:
May I leave a message on your phone? □ Yes □ No
□ Home: _____ □ Cell: _____ □Work: _____

May I email? □ Yes □ No
□ Personal: _____ □ Work: _____

May I text message your cell phone? □ Yes □ No

I understand that I am responsible for any portion of my bill that insurance does not pay. This includes *DEDUCTIBLES* and *CO-PAYS*. I also understand that 24 hours' notice must be given for a missed appointment or I will be responsible for the FULL FEE.

Client Signature _____ Date _____

Therapist Signature _____ Date _____