



# Client Update Form

1543 Lake Baldwin Lane  
Suite B  
Orlando, FL 32814

Your Counselor: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Phone: 407-894-5202

Fax: 407-894-5620

E-mail:

info@chariscounselingcenter.com

## GENERAL INFORMATION

Full Name:  Mr.  Mrs.  Ms.  Miss  Dr.  Rev. \_\_\_\_\_

Name you prefer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## CONTACT INFORMATION

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code : \_\_\_\_\_ May we send mail here:  Yes  No

Home Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code : \_\_\_\_\_ May we send mail here:  Yes  No

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ May we leave a message here:  Yes  No

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ May we leave a message here:  Yes  No

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ May we leave a message here:  Yes  No

Email Address: \_\_\_\_\_ May we send a message here:  Yes  No

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Mobile Phone: (\_\_\_\_\_) \_\_\_\_\_

## TERMS OF SERVICE

*I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.*

Credit Card Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Type of Card:  AMEX  VISA  MC