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Orlando, FL 32814
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Orlando, FL 32819
Titusville - 2323 Washington Ave, Suite 213
Titusville, FL 32780
Phone: 407.894.5202
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Client Update Form

Your Therapist: ______________________________
Today's Date: ______________________________

GENERAL INFORMATION

Full Name:____ Sex: ☐ Male ☐ Female

Name you Prefer: ____ Age: ____________ 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: ________________ Security Code: ___________________ Type of Card: ☐AMEX ☐VISA ☐MC ☐DIS

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