

**CLIENT INFORMATION**

PLEASE PRINT

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ RELIGION: \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PARTNER/MARRIAGE STATUS: \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

NO. OF PREVIOUS MARRIAGES: \_\_\_\_\_ AGES & SEX OF CHILDREN: \_\_\_\_\_

WHO DID YOUR GROWING-UP FAMILY CONSIST OF: \_\_\_\_\_

GOAL FOR LIFE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

STREET

CITY, STATE

ZIP CODE

SOCIAL SECURITY NUMBER: \_\_\_\_\_ CELL: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**EMERGENCY CONTACT:** NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

Fees for services are payable at the time service is rendered. If unable to keep your appointment, kindly give 24 h notice, otherwise, a charge will be incurred for your time reserved. Promptness is the responsibility of the client.

This office abides by all HIPPA Regulations. Should you wish to obtain a copy of those regulations, please ask the assistant for your copy.

I authorize Kristen Bomas to render necessary treatment. I agree to leave an imprint of my credit card for any payments not made at time charges are incurred. I agree to be responsible for any insurance benefits not paid to Kristen Bomas. I have read and understand the above and the attached policies. Please be informed that Kristen Bomas is NOT an insurance provider. We offer out of network benefits only.

\_\_\_\_\_  
PATIENT'S SIGNATURE