THE MARIPOSA CENTER LLC

FOR INFANT, CHILD & FAMILY ENRICHMENT

Client Contact Information

Client's Name:_____ Age:_____ Gender:____M ____F ____Other_____

Race/Ethnicity:_____Date of Birth:_____

Adult's Name (if client is a minor)_____

Employer:_____Occupation:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Phone: (Home) _____ (Work) _____ (Cell)_____

(circle all numbers above at which you give permission to be contacted)

Do you give therapist permission to leave a voice mail? Yes_____No_____

E-mail address(es):_____

Health Insurance information:

Name of insurance_____Phone number#_____

Policy and/or Member #_____ Group#_____

List the preferred way(s) for therapist to reach you:_____

Person(s) to Contact in Case of an Emergency:

1. Name_____Relationship to you_____

   Best way to contact this person_____

2. Name_____Relationship to you_____

   Best way to contact this person_____

I realize that there is a possibility that I may compromise the level of confidentiality when using cell phones and e-mail to communicate. Please indicate by placing your initials next to each means of communication to which you give your consent to use:

E-mail_____ Cell phone_____ Cell phone voicemail_____ Cell phone text message____

I also realize that the contact numbers for the therapists are cell phone numbers _____

Adult Client Signature _____ Date: _____

Parent Signature (if client is a minor)_____ Date: _____

Parent Signature (if dual custody of child)_____ Date: _____

Emily McNeil, LPC, R-DMT, EMDR-I Jennifer Platt, LPC, R-DMT, EMDR-I Debbie Carter, NCC, LPCC Eli Moch, LPC, ATR, EMDR-II
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