Jennifer L. Harkins, LPC, PLLC

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Telephone: Cell:_____ Work:_____ Home:_____

Name of Employer: _____ Occupation: _____

Social Security #_____ Married _____ Single _____ Divorced ___

Widowed _____ Separated ____ Other ____

Spouse/Partner's Name:_____

Date of Birth: _____Age:_____

Address (if different from above):

_____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Telephone: Home: _____ Cell: _____

Name of Employer: _____ Occupation: _____

Social Security #_____

Children's Names(s):	Age:	Name of Other Parent?	Lives with?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Background Information

Level of Education: _____ Currently a student? _____

Have you seen a counselor before? _____

How did you select this office? _____

May we let your referral source know you have contacted this office? _____

Problem that brought you to this office: _____

_____

_____

Who is your primary care physician? _____

May I contact him/her? ____ Telephone number_____ No_____

Address: _____
Street Address

_____
City *State* *ZIP Code*

Emergency Contact Name: _____ Relationship: _____

Cell Phone: _____ Alternate Phone: _____

CANCELLATION POLICY: If you need to reschedule or cancel an appointment, please call at least 24 hours in advance. If you miss a scheduled appointment, regular fees will be charged to you for that time. Sudden emergencies or illness can be discussed.

FINANCIAL RESPONSIBILITY STATEMENT: I understand that I am responsible for all of the charges incurred for services provided to me and/or my family. I agree to pay my account as services are provided unless other arrangements are made. If there is an outstanding balance on my account, I agree to pay it as soon as I am made aware of the amount owed.

In case of emergency I will call 911 or go to the nearest emergency room.

_____ _____

Signature Date