



Licensed Professional Clinical Counselor (CA LPC23)

Client Information

Name(s): _____ Date: _____

Address: _____

City: _____ Zip: _____

Home Phone (including area code): _____

Mobile Phone (including area code): _____

E-mail Address: _____

Do you wish to communicate via unsecure e-mail (see Privacy Practices)? ☐ Yes ☐ No

Marital status: _____

Date of Birth (Month/Day/Year): ____ / ____ / ____ Social Security # ____ - ____ - ____

Primary Care Physician: _____

Phone (including area code): _____

Address: _____

City: _____ Zip: _____

Please sign below if you consent to release information so that your therapist, Jamie Pedersen, LPCC, may contact your doctor for consultation.

Sign Here: _____

Emergency contact information: _____

Phone (including area code): _____

Referred by: _____

What is your primary form of payment? ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ HSA CARD



Jamie Pedersen

Licensed Professional Clinical Counselor (CA LPC23)



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Client Information (Parent or Guardian)

Client Name(s): _____ Age: _____

Parent or Guardian Name(s): _____

Relationship with Client: ☐ Parent Are you currently married to the client's other parent? ☐ Yes ☐ No

If No, do you have 100% custody of the child: ☐ Yes ☐ No

(The other parent will be required to provide written consent if not 100% custody)

Has the clients other parent provided consent for this therapy: ☐ Yes ☐ No

☐ Legal Guardian _____

Comment: _____

The above information is accurate and I am authorized to provide consent for therapy on behalf of the client

Initials _____

Address: _____

City: _____ Zip: _____

Does the client reside at the same address? ☐ Yes ☐ No (fill out the address information below)

Client Address: _____

Client City: _____ Zip: _____

Contact Phone (including area code): _____ ☐ Home ☐ Mobile

_____ ☐ Home ☐ Mobile

Do you authorize me to leave voicemails on the numbers above (see Privacy Practices)? ☐ Yes ☐ No

Contact E-mail: _____

Do you authorize me to communicate with you via unsecure e-mail (see Privacy Practices)? ☐ Yes ☐ No



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Parent Date of Birth (Month/Day/Year): ____ / ____ / ____ Social Security # ____ - ____ - ____

Parent/Guardian Marital status: _____

Parent Date of Birth (Month/Day/Year): ____ / ____ / ____ Social Security # ____ - ____ - ____

Primary Care Physician: _____

Phone (including area code): _____

Address: _____

City: _____ Zip: _____

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