Jamie Pedersen
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 **Notice of Privacy Practices**)? ☐ YES or ☐ 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

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