INTEGRATED WELLNESS AND STRATEGIES, PLLC
Amber W. Pearson, MA, LCMHC, EMDR-CT
Your path to healing and transformational growth...

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PRIVATE PAY CLIENT INFORMATION

GENERAL CLIENT INFORMATION

Date:_____ Client's Nickname: _____

Legal First Name:_____ Legal Last Name_____ MI: _____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Ok to leave a voicemail? ☐ Yes ☐ No Ok to leave a voicemail? ☐ Yes ☐ No

Date of Birth:_____ Social Security #: _____

Gender Identification: ☐ Male ☐ Female ☐ Other: _____

Relationship Status (please circle all that apply):

☐ Single ☐ Married ☐ Committed Partner/Spouse ☐ Divorced ☐ Widowed

School Status (circle only one): ☐ F/T Student ☐ P/T Student ☐ Not a Student

Employment Status (circle only one): ☐ F/T Employed ☐ P/T Employed ☐ Unemployed

Clients' Employer:_____Occupation:_____

How did you hear about me?_____

Note: If this is a person, I will not contact him/her, I am only asking for tracking purposes.

By signing below you certify that the information about the client in this document is correct. By signing below you also provide express consent to treatment with Amber W. Pearson and Integrated Wellness and Strategies, PLLC and decline insurance benefits from your insurance carrier related to this treatment. In addition, you hereby authorize Amber W. Pearson, Integrated Wellness and Strategies, PLLC, its staff, and its billing agency to release any information necessary to secure payment in accordance to HIPAA standards.

Client Name (printed) Client Signature Date

☐ Copy provided to client.