



# INTEGRATED WELLNESS AND STRATEGIES, LLC

Amber W. Pearson, MA, LPC, LCMHC, LMHC, EMDR-CT

*Your path to healing and transformational growth...*

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strategiesintegrated.com

## 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.*

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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, LLC and decline insurance benefits from your insurance carrier related to this treatment. In addition, you hereby authorize Amber W. Pearson, Integrated Wellness and Strategies, LLC, 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