CLIENT INFORMATION (MINOR)

DAVE KAPLOWITZ, LMFT, CGP

3355 Bee Cave Rd Suite 104 West Lake Hills, TX 78746 (512) 814-7127

Client Name: ____ Date: __________________

Date of birth: _______________________ Age: _________ Gender: ________________

Address: ____

City: ____ State: _____ Zip: ________

School: ____

Phone: ___________________________ ☐ Cell ☐ Home ☐ Work ☐ Other: _____________

Your signature below indicates that you have read the Notice of Privacy Practices and the Client Agreement and agree to abide by their terms during our professional relationship.

Client Signature: _______________________________________ Date: ___________

Parent(s) or Legal Guardian(s)

Your signature below indicates that you have read the Notice of Privacy Practices and the Client Agreement, that you agree to abide by their terms during our professional relationship, and that you give your consent for treatment of your minor child.

Name: ____ Relationship: _______________

Signature: ______________________________________ Date: ___________

Name: ____ Relationship: _______________

Signature: ______________________________________ Date: ___________