Counseling Solutions Inc.
Nina Flowers, LPC
www.conslsolutions.com
703-858-5507

Client Contact Information

(Please print carefully)

Client Name: _____ _____ _____
First Middle Last

Home Address: _____
Street Address (Including Apt/Ste)

_____ _____ _____
City State Zip code

Client Social Security Number: _____ Date of Birth: _____

If Client is a Minor, the Parent/Guardian should complete the following:

Parent or Guardian: _____

Relationship: _____ Address (if different): _____

Referred to by: _____ Tel: _____

Contact Information:

Home Tel: _____ Work Tel: _____

Mobile/Cell: _____ Email: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Home Tel: _____ Work Tel: _____

Mobile/Cell: _____

Payment is Expected at Time of Service

Cancellation Policy

A 24 hour advance notice is required for cancellation of your scheduled appointment.
A $50 missed appointment fee will be charged for missed appointments without notification.

Certification and Authorization

I certify that the information above and that contained in my Client Intake Form is accurate.

Signature of Client (or Parent/Guardian): _____