Garet Bedrosian, LCSW, CIRT, CBT, CET
LCS 11814

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Client Information
(Please Print Clearly)

Client Name _____ SS# _____ DOB _____

Age _____ Birthplace _____ Sex _____ Status (Circle) S M DP D W

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Occupation _____ Employer _____

Parent/Spouse/Partner Name _____ Employer _____ Phone _____

Referred By _____ Phone _____ May I Thank Them? _____

Name of Responsible Party if Not Client _____ Cell Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Phone _____ Ext _____

Occupation _____ SS# _____ DOB _____

Fee Structure: Please speak with Garet about fees.

Please pay fees and discuss scheduling or other business related issues at the beginning of each session so the remaining time can be used for your growth and healing.

Authorization to Treat: I authorize and direct Margaret "Garet" Bedrosian, LCSW, CIRT, CBT, CET to perform such therapeutic procedures that her professional judgment may indicate to be advisable for the well being of myself, my child and/or my family. I understand that no warranty or guarantee is made as to the results of this treatment.

I understand that insurance companies do not pay for missed appointments.

I agree to assume financial responsibility for the session fee charged for a failed appointment cancelled with less than 24 hours notice.

Please sign below if you agree to the stated terms.

Signature_____**Date**_____

Signature_____**Date**_____