Tiffany Smith Counseling, Inc.
2901 Corporate Circle
Flower Mound, TX 7502
(214) 405-4030
tiffanysmithcounseling@yahoo.com

PARENT/GUARDIAN FORM

Date of First Appointment: _____ Email _____
Name: _____
Last First Middle

_____
Address

_____
City *State* *Zip Code*

Phone numbers: _____ _____ _____
Home *Cell* *Work*
May I leave a message for you at home? Y / N
May I leave a message for you at work? Y/ N
May I leave a message for you on your cell? Y/ N
May I contact you via email? Y/ N

Please list the email address that you wish to be contacted at (we do not release email addresses):
_____

If you would like to be able to sent text messages to schedule/cancel appointments, please provide us the phone number and authorization to respond to these text messages:
Phone number for texting:_____
Signature:_____ Date:_____

Briefly describe your reason for seeking counseling: _____
_____
_____
What goals do you hope to achieve by attending counseling?_____
_____
_____

Have you ever previously attended therapy or received counseling services of any kind? Yes____ No_____ If yes please list the type of therapy you received_____

Did you find treatment helpful?_____

Previous therapist: _____

Reason treatment terminated?_____

Do you anticipate being involved in a lawsuit in the near future? Y/ N
If yes, please explain_____
_____

Have you ever been a party to a lawsuit? Y/ N
If yes, please provide a description of the suite, the date, and the outcome:
_____
_____

Have you ever filed a complaint with a licensing or regulatory authority? Y/ N
If yes, please provide a description of the suite, the date, and the outcome:
_____
_____

How did you hear about us?_____
_____

Customer Satisfaction Survey: Upon discharge we will ask you to complete a client satisfaction survey. The survey is anonomous and confidential and is used so that we can improve the quality of our services. Please provide us with your email address. We do not release email addresses to third parties.
I would like the survey sent to my email address at:
_____

Would you like to receive our quarterly e-newsletter? Yes/ No

I authorize payment of medical benefits to the provider of services, and the release of any treatment information necessary to process claims or obtain authorizations for treatment:
Signature _____ Date _____