



Dr. Brenna Tindall, Psy.D., CAC III
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Client Information Form

Client/Patient Information:

Client/Patient Name: _____
Date of Birth: _____
Social Security Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____
Mobile Phone: _____
Work Phone: _____
Email Address: _____
Employer/School: _____
Employer/School Address: _____
City: _____ State: _____ Zip Code: _____

Previous Counseling and/or Psychiatric Treatment:

Name of Provider: _____
Length of Treatment: _____
Medications (please include dosages if known):

Emergency Contact Information:

Name: _____
Relationship to Client: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____
Mobile Phone: _____
Work Phone: _____

Who Were You Referred By?

Name: _____
May I contact this person to thank them? Yes: _____ No: _____

Responsible Party:

If you are the parent or legal guardian of a client/patient who is under the age of 18, please complete the following with your information. If you are over the age of 18, please proceed to the next section of this form.

Name of Parent or Legal Guardian: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Email Address: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Form of Payment

Please indicate the form of payment you wish to use for any services rendered through our practice. We accept the following forms of payment: Visa, MasterCard, Discover and Electronic Checks. Service fees will be deducted from the designated account at the time services are rendered. This information will be securely stored in your clinical file and may be updated upon request at any time.

Payment Type:

Credit (Debit) Card (VISA or MASTERCARD): _____

Check: _____

Cash: _____

Account Holder Information:

Please indicate the name and address associated with your credit or debit card.

Name: _____

Address: _____

Account Information:

Card Type: Visa MasterCard Discover

Card Number: _____

Expiration Date: _____

I certify the information provided above is accurate to the best of my knowledge. I also authorize any service fees to be deducted from the form of payment designated on this form. Should any of the information provided change, I agree to update my provider as soon as possible.

Signature of Client or Legal Guardian

Date