

Greg Milbourne, Psy.D.
Licensed Clinical Psychologist, PS015613
Client Information Sheet

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Work phone: _____ Cell phone: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? . Yes . No

C. Your current employer

Employer: _____ Address: _____

Work phone: Calls will be discreet, but please indicate any restrictions: _____

D. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name: _____ Current age: _____ Sex: _____

School: _____ Grade: _____ Adjustment problems? _____ P? _____

Name: _____ Current age: _____ Sex: _____

School: _____ Grade: _____ Adjustment problems? _____ P? _____

Name: _____ Current age: _____ Sex: _____

School: _____ Grade: _____ Adjustment problems? _____ P? _____

Statement of Confidentiality

As a psychologist, I seek to provide the quality of services required by the standards of professional psychologists. In keeping with those standards, strict confidentiality of all records of contact is maintained. It is policy **not** to release personally identifiable information concerning the use of services without prior permission of the person receiving the services. Legally and ethically, confidentiality cannot be maintained when: (1) there is a clear and present danger than someone's life is at risk; (2) in the apparent abuse of a minor; and (3) subpoenaed in a criminal (not civil) judicial proceeding. If you are concerned about or have questions regarding confidentiality, please discuss them with me. **I have read the above statement.**

Your signature below indicates that you have read the **HIPAA Agreement** and agree to its terms and also serves as an acknowledgement of your familiarity with the **HIPAA Notice Form**.

Client Signature

Therapist Signature

Parent/Guardian Signature

Date