INTAKE REGISTRATION FORM - CONSENT FOR TREATMENT OF ADULT

Please print all information except signature

REGISTRATION INFORMATION

LAST Name _____ **FIRST Name** _____ **DOB** _____ **Age** _____

Address _____ **City** _____ **Zip** _____

Home # ( ) _____ Work # ( ) _____Cell: ( )_____

Occupation _____ **Employer** _____

Referred by _____ **Relationship to You:** _____

CONSENT FOR TREATMENT OF ADULT

Patient Name _____ **(please print)**

Therapist ☐ **Barry C. Barmann, Ph.D.** ☐ **Mary B. Barmann, MFT**
California Lic. # PSY10035 **Lic. # MFC21169**
Nevada Lic. # PY0672

This is to certify that I give permission to the Therapist checked off to provide counseling and psychotherapy to me. This treatment may include individual or group psychotherapy, testing, and consultations with Psychologists, Counselors, Physicians, as stipulated in a signed and completed Release of Information form. In some cases, the California courts have held that if an individual intends to take harmful or dangerous action against self or others, it is the therapist's duty to warn the person and/or the family of the person who is likely to suffer the results of harmful behavior. Every effort will be made to resolve such issues before such a violation of confidentiality takes place.

CONSENT TO CONTACT – Check off (✔) appropriate boxes

You may contact me with information regarding my treatment using the following methods:

☐ **Home Phone** ☐ **Work Phone** ☐ **Cellular** ☐ **Text Message** ☐ **Home Address**
☐ **Email (use this email address):** _____

My written signature indicates that I have read and understood the policies of the Behavior Therapy and Family Counseling Clinic and agree to abide by such policies. A photocopy of this document shall be as valid as the original

Signature of Patient _____**Date:** _____
Printed Name of Above Person _____
Witness/Therapist _____ **Date** _____

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