INTAKE REGISTRATION FORM REGARDING THE CONSENT FOR TREATMENT OF AN ADULT

LAST NAME: ___________________________________ FIRST NAME:__________________________________

DOB:________________ AGE:_____________

ADDRESS: ____________________________________ CITY: __________________ ZIP: __________________

HOME PHONE: ___________________ CELL: _________________ WORK: _______________________________

OCCUPATION: ___________________ EMPLOYER: ____

REFERRED BY: _______________________________ RELATIONSHIP TO YOU: ___________________________

You may contact me with information regarding my treatment using the following methods: Check off (✓) appropriate boxes:

□ 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 Dr. Barry C. Barmann (DBA: Center for Anxiety & Chronic Worry) 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:______________________

This is to certify that I give permission to Dr. Barry C. Barmann to provide psychotherapy to me. This treatment may include individual, group, or family therapy, psychological assessment, and/or consultations with other therapists, and/or physicians, as stipulated in a signed Release of Information Form. In some cases, the State of Nevada and California courts have mandated 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 patient confidentiality takes place.

Therapist: Barry C. Barmann, Ph.D. DBA: Center for Anxiety & Chronic Worry
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