Reid Counseling Group PLLC

Daniel Reid Johnson MEd. LPC.

Confidential Client Data

This information is for office admin and to better understand you and your situation.
All information will be held in strict confidence.

Date: _____/_____/_____

Personal Information

Name: _____ Birthdate: ____ /____/____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Sex: ____ M ____ F Marital Status: _____ E-mail: _____

SSN: _____-_____-_____ Referred by: _____

Responsible Party

Name: _____ E-mail: _____

Relationship to client: ___ Self ___ Spouse ___ Child ___Other (please indicate): _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Previous Counseling or Psychotherapy

From whom: _____

Address: _____ City: _____ Zip: _____

Approximate Dates: _____

Focus of therapy? _____

Credit Card Authorization Form

I authorize REID Counseling Group PLLC to charge this credit card for services rendered, in the case of a missed appointment, or an appointment not canceled at least 24 hours in advance.

I understand it is my responsibility to keep an updated copy of my credit card information on file. If my credit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check.

Client Signature Date

Name as it appears on card _____

___MasterCard ___VISA ___AMEX Card # _____
CCV _____ Expiration _____

Billing address ***if different from above***.