Dan Drake, MFT, LPCC, CSAT

Licensed Marriage and Family Therapist, MFC 49986
11712 Moorpark St., Ste. 111, Studio City, CA 91604
www.dandrakemft.com

Licensed Professional Clinical Counselor, LPC 327
(310) 415-5732
dan@dandrakemft.com

PERSONAL INFORMATION and CONSENT FOR SERVICES

Client Contact Information

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Identifying Information

Gender: _____ Age: _____ DOB: _____ Marital/Partnered Status: _____

Children (#): _____ Age(s) _____

Job Title: _____ Employer (name & address): _____

Primary Physician (name & phone): _____

Referral Source: _____

Please indicate whether it's OK to leave a message or contact you on your voice mail/answering machine, via email, and/or via text message: YES NO

I _____consent to and authorize mental health services by Dan Drake, LMFT for myself.
Print Name

All sessions and their content will be considered confidential and will not be shared with any outside party without your prior written consent to do so and/or by signing the consent form provided, excluding consultation with other mental health treating individuals related to your treatment. Exceptions to confidentiality are in cases of child (under 18), elder (65+), and dependent adult abuse and neglect (18-64), or potential self-harm or harm to others.

I understand that in case of non-payment on my account, some of my information may be disclosed to collection agencies in order to collect the money due. **I understand that if it is necessary to cancel an appointment I must give at least 24 hours notice. If notice is not given 24 hours prior to appointment time, I understand that I will be charged the *FULL* fee for the missed appointment.**

_____ _____
Client's Signature Date

_____ _____
Signature of parent/guardian if client is a minor Date

*Please see the additional sheets for other agreements & information.