Clayton Private Practice

105 S. Ellington St. ♦ Clayton, NC 27520
Phone: (919) 243 – 0454 ♦ Fax: (919) 243 – 0923

Name (legal name of person being seen): _____

Date of Birth: _____ **Age:** _____ **Today's Date:** _____

Client Demographics:

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race: ☐ Asian ☐ Black or African American ☐ White or Caucasian /Euro American
☐ Native American ☐ Mid Eastern ☐ Latino ☐ Native Hawaiian/Pacific Islander
☐ Other: _____

Veteran: ☐ Yes ☐ No

Address: _____

City / State / Zip: _____

Phone(s): _____

Legal guardian(s): ☐ Self ☐ Other (**Name**): _____

School & grade or **Occupation**: _____

Consent for Treatment

I authorize the evaluation and/or treatments of the client identified above and agree to pay all charges for the evaluation and/or treatment provided.

Consent for Emergency Care

I consent to Emergency Medical Care: This is to authorize Psychological Mobile Services, PA to seek emergency medical care if needed. It is understood and agreed that the staff and Psychological Mobile Services, PA will be held harmless for any and all results of the staff's efforts to obtain emergency medical treatment including any accident or injury while being transported.

In case of emergency contact:

Name: _____ Relationship: _____ #: _____

By signing below you agree to all terms and conditions defined above regarding **1)** Treatment consent **2)** Emergency consent

X _____ _____

Member / Guardian Sign ***Date***