KYLE WILLIAMS LMSW ACSW

Solution Focused Individual and Family Therapy

CLIENT PROFILE

* Please skip information below that is irrelevant – alternate addresses, phones, etc

Date Prepared _____

Name: _____

Mailing Address: _____

City/State: _____Zip: _____

Telephone: _____ Messages OK? Y / N

Text: _____ Messages OK? Y / N

E-mail Address _____

(For your privacy, telephone, text and email messaging is for appointment purposes only – not for discussion of therapy related issues)

Date of Birth: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Your signature below indicates that you have read the information in the **Therapy Agreement** and agree to abide by its terms during our therapy relationship.

Client_____ Date _____

Therapist_____ Date _____

KYLE WILLIAMS LMSW ACSW

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Credit Card Processing Agreement

I, _____ hereby authorize Kyle Williams LMSW, ACSW to keep my signature on file and charge my credit card for therapy services. The charge will appear as "KyleWilliams.net." via Authorize.net

I understand that I will typically be billed at the end of the month in which my therapy session(s) occur.

I authorize Kyle Williams LMSW, ACSW to bill my credit card for additional therapy services as specifically agreed upon in advance by both parties.

I understand that I am responsible for fees incurred in the unlikely event of declined credit card charges.

This agreement will be in effect until services have been completed or until Kyle Williams has received written notification of termination in writing.

My credit card information:

[ ] Visa **[ ] Mastercard** **[ ] American Express**

Credit Card Number: _____

Expiration Date: _____

Card holder's Signature: _____