Meryl H Brownstein, M.Ed.
Licensed Professional Counselor of Mental Health

Name_____Date_____

Address_____

City_____State_____Zip_____

Sex: M_____F_____

Relationship Status_____

Home Phone(___)_____Work(___)_____Cell(___)_____

Date of Birth_____Age_____

Email_____OK to email? Yes_____No___

Who referred you to my practice?_____

Address_____

City_____State_____Zip_____

Phone_____

Do I have permission to send them a "Thank You" for the Referral Note?

Yes_____ No_____

If someone other than you is responsible for payment:

Name_____

Address_____

City_____State_____Zip_____

Home phone_____Work_____cell_____

Please Read:

I understand that I am responsible for my bill. I also understand that 24 hours notice must be given prior to canceling an appointment or I will be responsible for payment in full.

Signature_____Date_____