

James J. Sanders, LMFT, LPC CCMHC

Confidential Client Information and Fee Agreement

Name: Last: _____ First: _____ Date: _____

Date of Birth: _____ Age: _____ Address: _____ Zip _____

Gender: _____ Home ph: () _____ Work ph: () _____

Cell ph: () _____ E-mail: _____

Do I have your permission to correspond and/or leave a message? _____

Family living in home:

Name	Age	Relationship	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How were you referred here? _____ May I thank them? _____

Reason for visit? _____

Any communication between you and me will NOT be shared with anyone, except for possibility of abuse of a child, abuse of dependent adult or senior of 65 years of age or older, imminent danger to self or others, or specified by CA law. If requested, I will give you a bill if you want to submit it to insurance. Half of the fee is charged unless cancelled 24 hours in advance. I too will respect your time. Please ask any questions any time.

I understand and agree to the above.

Signature _____ Date: _____