Bill Jacobs
Clinical Counselor

(505) 379-0810
bill@billjacobslpcc.com

Client Information

(Please print)

Name _____ Date of birth _____

Address _____

City _____ State _____ Zip code _____

Email Address _____

Phones: Cell (_____) _____ Home (_____) _____Work (_____) _____

May we leave you text or voice messages on your cell phone? Yes _____ No _____

Gender: M _____ F _____ Married _____ Single _____ Employed _____ Student _____

Occupation _____ Employer _____

School_____Major/Grade _____

Mother's name (if client is under 18) _____

Phone (_____) _____

Father's name (if client is under 18) _____

Phone (_____) _____

Referring provider or other referral source _____

Release of Information

I authorize Bill Jacobs, Clinical Counselor, to release appropriate information regarding my treatment to the referring physician or other provider, doctor or any other professional to whom I am referred by the above clinician for continuity of care.

Signature _____ Date _____

Staff use only

Dx _____ CPT _____