MICHELE SAFFIER

& ASSOCIATES

Licensed Marriage & Family Therapist • Certified Sex Addiction Therapist • EMDR Level III Trained Practitioner

Patient Information

Name_____

Age_____

Gender_____

Date of Birth_____

Home Phone_____

Work Phone_____

Cell Phone_____

Address_____

City_____

State_____Zip_____

E-mail_____

Marital Status_____

Education_____

Occupation_____

Referred by_____

Employer_____

Address_____

Emergency Contact_____

Phone_____

Family Physician_____

Phone_____

Address_____

City_____

State_____Zip_____

Spouse/parent Information

Spouse/parent_____

Who has primary guardianship_____

Occupation_____

Spouse/Parent Employer_____

Work Phone_____

Address_____

City_____

State_____Zip_____

Our office policy requires payment at the time of service unless otherwise arranged. A 24 hour notice of cancellation is required in order to avoid being charged for a missed appointment. By my signature below, I consent to the release of information as necessary for collection of services being billed.

Name_____Signature_____ Date___

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