

MICHELE  SAFFIER  
& ASSOCIATES

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

**Patient Information**

**Spouse/parent Information**

Name_____	Spouse/parent_____
Age_____	Who has primary guardianship_____
Gender_____	Occupation_____
Date of Birth_____	Spouse/Parent Employer_____
Home Phone_____	Work Phone_____
Work Phone_____	Address_____
Cell Phone_____	City_____
Address_____	State_____ Zip_____
City_____	
State_____ Zip_____	
E-mail_____	
Marital Status_____	
Education_____	
Occupation_____	
Referred by_____	
Employer_____	
Address_____	
Emergency Contact_____	
Phone_____	
Family Physician_____	
Phone_____	
Address_____	
City_____	
State_____ Zip_____	
Name_____	Signature_____ Date_____

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.