GROWING EDGES

Individualized therapy for dealing with life challenges

DSM _____
(Office Use Only)

Ilyssa Swartout, Psy. D.
18205 N. 51st Avenue
Building 2, Suite 115
Glendale, AZ 85308

602-548-1444 Office
602-548-1446 Fax
602-463-6854 Voice Mail

Client Information

Date of First Appointment: _____ Referred by: _____

Personal Information (All areas marked with a * MUST be completed)

*Client Name: _____ Nickname: _____
First *MI* *Last*

*Home Address:
_____
Street *City* *State* *Zip*

*Client's E-mail Address: _____@_____
Client's Home Phone #: (_____) _____
Client's Business Phone #: (_____) _____
*Client's Main Cell Phone #: (_____) _____
Other Important Phone #: (_____) _____ *Type of #? _____
* Client's Social Security #: _____ -_____ -_____
* Client's Date of Birth: _____ /_____ /_____ Age: _____
* Client's Gender (circle one): Female Male
* Client's Martial Status (circle one): Single Married Other (Other includes Divorced, Widowed & Domestic Partnerships)
* Client's *School OR Work Status (circle only one): F/T Student P/T Student OR Employed Not Employed*

Family Information (All areas marked with a * MUST be completed)

Immediate Family Members:
*Spouse's Name: _____ Age: _____
First *MI* *Last*
Spouse's Employer: _____
Spouse's Business Phone #: (_____) _____
*Children/Siblings (First names & ages only):
_____
_____
_____
_____
*Other Extended Family Members Living With Client:
Name: _____ *Relationship to client: _____
Name: _____ *Relationship to client: _____

Emergency Contact Information (All areas marked with a * MUST be completed)

***Name: _____ *Relationship to client: _____**

*** Contact Phone #1: (_____) _____**

*** Contact Phone #2: (_____) _____**

***Emergency Address:**

_____

Street City State Zi

To (re) schedule appointments your therapist will call the numbers listed on page 1.

May therapist leave a message on an answering machine? Yes__ No___
May therapist leave a message with someone at these numbers? Yes__ No___
May therapist leave an email message? Yes__ No___

How did you hear about us? (Please circle)

Insurance Co Friend Client of ours GoodTherapy.org Dex Online

Psychology Today Website Yellow Pages (book)

Google Search Words _____ Which brought you to _____

Doctor _____
Name

Other Person who referred you _____

APPOINTMENT CANCELATION POLICY: Growing Edges LLC requires that cancellations for scheduled appointments be received 24 hours in advance. Unkept or cancelled appointments that do not follow this policy will be charged an unkept appointment fee at the discretion of your therapist. This fee can equal but will not exceed the therapist fee for the time originally scheduled.

At the end of every session you will receive an appointment card with the date and time of your next appointment. Please keep this card in case there is a misunderstanding concerning the date or time of your appointment. If you miss or cancel an appointment in less than 24 hours from the time of your scheduled appointment, or arrive for an appointment on the wrong day or time, you will be responsible for paying for that session. If I cancel an appointment in less than 24 hours of your scheduled time, or if I have put you in my schedule at the wrong time, then your next session is free. This will be verified when you bring in the appointment card you were given.

I have read and understand the above stated policy of Growing Edges LLC.

_____ _____

Signature of Responsible Party (required): Date

I give my permission for Ilyssa Swartout, Psy.D. to charge my credit card, if I cannot be there in person, in the even of:

- A missed appointment _____ (initials)
- A teleconference session _____ (initials)
- A minor child attended the session _____ (initials)
- _____ attended session _____ (initials)
- Any unpaid balance - 30 days or more _____ (initials)

Signature of card owner _____ Date _____

(Print name) _____

CC # _____

Expiration Date _____

3-digit code _____

Zip Code _____