CLIENT COMMUNICATION INFORMATION AND CONSENT

From time to time, it becomes necessary for your therapist to contact you regarding appointment times, insurance requirements, your account or other reasons related to your treatment. Please record your preferences below, including at least one verbal and one written form of communication. (Indicate your selections with a check-mark and complete information.)

TELEPHONE COMMUNICATION

___Home # _____

_____ Detailed Message OK

_____ Leave Callback # Only

Work # _____ Ext.

Detailed Message OK

Leave Callback # Only

Cell phone # _____

Detailed Message OK

Leave Callback # Only

WRITTEN COMMUNICATION

Home Address:

_____

_____

Work Address:

_____

_____

_____

Alternate Address:

_____

_____

_____

I authorize Gary Gabbard, L.P.C., and his office staff to contact **me** as indicated above.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

(This release can be amended in writing upon client's request.)