



# Jess Albright, LCPC, ACS

Licensed Clinical Professional Counselor

## Young Adult/Adult Personal Information

**Client Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Phone: (home)** \_\_\_\_\_

**(cell)** \_\_\_\_\_

**Email:** \_\_\_\_\_

### Referred by/ Where Did You Hear about Jess Albright, LCPC, ACS:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Internet (please specify) | <input type="checkbox"/> family/friend |  |
| <input type="checkbox"/> Good Therapy              | <input type="checkbox"/> Google search | <input type="checkbox"/> professional referral |
| <input type="checkbox"/> Psychology Today          | <input type="checkbox"/> Bing search   | <input type="checkbox"/> magazine ad           |
| <input type="checkbox"/> Other: _____              | <input type="checkbox"/> Other: _____  |  |

### Financial Agreement

I understand that payment is expected at the time of service. A fee of \$25 will be assessed for any returned checks. I understand that I will be responsible for full payment if I do not give 24 hours notice of cancellation or change of appointment. I also understand that failure to maintain responsibility for payment may result in my account being sent to an independent agency for collection. I consent to the release of information for this purpose, and I agree to pay any costs associated with such collection.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date