Jess Albright, LCPC, ACS

Licensed Clinical Professional Counselor

Tween/Teen Personal Information

Client Name: ____

DOB: __________________

Address: ____

____

Phone: (home) ____________________________

(cell) ____________________________

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

☐ Internet (please specify)

☐ Good Therapy ☐ Google search

☐ Psychology Today ☐ Bing search

☐ Other: ____________

☐ family/friend

☐ professional referral

☐ magazine ad

☐ Other: ________________

For clients younger than 18 years of age, please complete the following:

Father: ____

Address: ____

____

Phone: (home) ____________________________

(cell) ____________________________

(work) ____________________________

Email: ____

124 N. Court Street, Frederick, MD 21701 240-457-9015
counselingwithjess@gmail.com www.counselingwithjess.com

Mother: ____

Address: ____

____

Phone: (home) ______________________________

(cell) ______________________________

(work) ______________________________

Email: ____

Primary Care Physician: ____

Phone Number: ____

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/Parent/Guardian Date