Mandy Jordan, PhD
Trauma Specialist

NEW CLIENT INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE NAME:
ADDRESS:		
CITY:	STATE:	ZIP:

DATE OF BIRTH:	REFERRED BY:
HOME PHONE: ( )	LEAVE A MESSAGE? ____YES_____NO
CELL PHONE: ( )	LEAVE A MESSAGE? ____YES_____NO
WORK PHONE: ( )	LEAVE A MESSAGE? ____YES_____NO
EMAIL ADDRESS:	
OK to leave confidential, detailed message?_____Yes ____No	
PERSON TO CONTACT IN CASE OF EMERGENCY:	
RELATIONSHIP TO YOU:	CONTACT PHONE: ( )

INFORMED CONSENT FOR TREATMENT

I authorize and request that Mandy Jordan, PhD, carry out psychological assessments, diagnostic procedures and/or treatments which, now or during the course of my care as a client, as advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

Signed by client: _____ Date: _____

CONFIDENTIALITY

All information between counselor and client is held in strict confidence by the counselor. There are specific and limited exceptions to this confidentiality which include the following:

1) The client authorizes release of information by signature as specified on the Release of Information Form;
2) Where there is a clear threat to do serious bodily harm to yourself or others;
3) Where there is reason to suspect the occurrence of abuse or neglect of a child, a dependent adult or a person with developmental disabilities;
4) In response to a subpoena that is associated with a regulatory complaint or in response to a subpoena from a court of competent jurisdiction;
5) Information that must be provided to insurance companies and/or EAP entities as required for the payment of claims, certification/authorization or case management or other purposes related to the benefits of client's health plan.

I have read and understand the HIPAA policy statement provided to me by my counselor:

Signed by client: _____ Date: _____

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