FORENSIC COUNSELING SERVICES

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Program Director

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ADULT DATA FORM

Please fill this form out completely. You are responsible for providing updates if any information changes.

Your Name: _____
Last First Middle Maiden/Other names by which you are known

Present Address: _____
Street Apt. # City State Zip Code

Telephone Numbers: _____
Home Work Cel Fax

Age: _____ Date of Birth: _____ Drivers License: _____
Number/State

Occupation: _____ Employer: _____

Referred by: ❑ Family ❑ Friend ❑ Website ❑ Other: _____

Are you enrolled in a group health plan, group individual health insurance, federal health care program or FEHB program? ❑ Yes ❑ No

If yes, are you seeking to have a claim submitted for services to the plan or coverage? ❑ Yes ❑ No

I understand that I am responsible for my fee payment at or before the beginning of each appointment. I understand that Dr. Robb does not bill insurance directly, but will provide a statement of services so that clients can seek insurance reimbursement if desired. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I hereby acknowledge I am requesting treatment by Dr. Robb, but that I am not a client of Dr. Robb until he formally accepts me for treatment. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible for any balance due prior to a decision to stop.

Your Signature: _____ Date: _____

Relationship to child(ren) if minors are involved in treatment: _____