Crossbridge Counseling
2000 S. Winton Rd, Bldg. 4, Suite 200, Rochester, NY 14618
Provided by The Mental Health Counseling Group, PLLC and The Marriage and Family Therapy Group, PLLC

**Confidential Client Information Sheet**

Name: _____ Date:_____

Address: _____
Street City Zip code

May we leave a message?_____ May we text for appointment verification_____

Phone(s): _____
Home Cell Other

Emergency Contact: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Occupation: _____

Employer: _____

How did you hear about Crossbridge Counseling? _____

Primary Physician's Name, Address and Phone: _____

_____

Please describe what brings you in today: _____

_____

_____

My signature below indicates I understand I will be working with licensed mental health counselor in her capacity as a mental health counselor. The counselor will not disclose any of my confidential information except if: she is ordered by a court to disclose information, you (the client) direct her to tell someone and sign consent for release of information, the counselor determines that you are a danger to yourself or others, or you reveal that you or someone you know are abusing a child (federal law mandates this be reported). I agree to give the counselor 24 hours' notice if I need to change an appointment. If less than 24 hours I agree to pay for the appointment.

Client Print Name: _____

Client Signature/Date: _____