



Advanced Counseling - Rod Limb M.Ed., LCPC, LMFT
39 W. Pine Ave. Meridian Idaho 83642
Phone: 208 887-6283

Today's Date _____

Preferred Name: _____ Full Legal Name: _____

DOB: _____ Age: _____ Sex: ___ M ___ F SSN: _____

Address: _____

City _____ State _____ Zip _____

Primary Contact Phone: _____ Secondary Contact Phone: _____

E-MAIL _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Other

Whom may I thank for referring you? Name : _____

Contact Info: _____

My Employer is: _____

In case of Emergency, who would you like contacted? _____

Address and phone: _____

____ I have verbally discussed Confidentiality boundaries and limitations with my Counselor

____ I understand Advanced Counseling's Informed Consent and other information is available online at www.rodlimb.com or I may request a printed copy of the Full Disclosure.

____ I understand to be responsible to pay full amount any missed appointments and charged 1/2 of late cancelled or rescheduled appointments not 24 hours before a scheduled appointment.

____ I consent and appreciate notification of future appointments by email &/or text understanding this may compromise my confidentiality of my attending counseling if someone reads my email or texts.

Reason for Seeking Services _____

____ Personal Stress ___ Relationship Stress ___ Family Issues ___ Work Stress ___ Hypnotherapy

My Number One Goal is: _____

Patient or Guardian Signature: _____ Date: _____

Print Name if Guardian: _____ Relation to Client: _____

(*Signing Parent or Guardian of Minor is Responsible for Incurred charges.)

By signing this form I understand that all services to me or my minor children I am fully responsible directly for making full payment as charged. In the unlikely event of non-payment I understand I may be additionally responsible for added cost of collection fees; this is typically 25%.