

# CLIENT INFORMATION

DAVE KAPLOWITZ, LMFT

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Your signature below indicates that you have read the Notice of Privacy Practices, the Client Agreement, the Social Media Policy, and the Technology-Assisted Therapy Policy and agree to abide by their terms during our professional relationship.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_