

CLIENT INFORMATION (MINOR)

DAVE KAPLOWITZ, LMFT

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Name: _____ Date: _____

Date of birth: _____ Phone: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

School: _____ Grade: _____

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: _____

Parent(s) or Legal Guardian(s)

Your signature below indicates that you have read the Notice of Privacy Practices and the Client Agreement, that you agree to abide by their terms during our professional relationship, and that you give your consent for treatment of your minor child.

Name: _____ Relationship: _____

Signature: _____ Date: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____