Kathy Elias, LCMHC, LCAS, NCC, 283 Glen Road, Suite B, Garner, NC 27529

Contact Information

Client Name: _____ Age: _____ Date of Birth: _____

Address: _____
City State Zip Code

Emergency Contact Name/Relationship: _____

Emergency Contact Phone: _____

Referral Source: Friend Former Client Psychology Today Insurance Co. Mental Health Agency Website

Physician (Name) _____ Other Professional (Name)_____

How may I contact you?

____Home Phone ____Cell Phone ____Work Phone

What is your preference for contact?

____Home Phone ____Cell Phone ____Work Phone

May I leave a voice message? _____Yes _____No

May I leave a text message if necessary ____Yes ____No

_____ Home Cell Work Other (please circle one)
Phone

_____ Home Cell Work Other (please circle one)
Phone

_____ Home Cell Work Other (please circle one)
Phone

_____
Email address

I understand that electronic communication such as text messaging and email may not be a secure form of contact, and that if I choose to communicate with my therapist by using these means that I do so at my own risk.

I certify that the above information is accurate:

_____
Signature of Client (or guardian) Date