

FAMILY PINNACLE, LLC
Susan K. Daniel, Psy.D.
761 Maitland Avenue
Altamonte Springs, Florida 32701
Phone: (407) 740-0208
Fax: (407) 740-0242

NEW CLIENT INFORMATION

NAME _____ DATE _____

ST. ADDRESS _____ CITY _____ ST _____ ZIP _____

EMAIL ADDRESS _____ CELL PHONE () _____

WORK NUMBER () _____ MARITAL STATUS _____

OCCUPATION _____ DOB _____ YRS. EDUCATED _____

If the client is a minor, please list the name, address and relationship of the responsible parent/guardian:

NAME _____ RELATIONSHIP _____

ST. ADDRESS _____ CITY _____ ST _____ ZIP _____

EMAIL ADDRESS _____ CELL PHONE () _____

WORK () _____ REFERRED BY _____

PRIMARY CARE PHYSICIAN _____ PHONE NO. () _____

Please describe your problem or reason for the referral:

Please describe any prior psychological services:

OTHER FAMILY OR MEMBERS OF HOUSEHOLD

NAME	AGE	RELATIONSHIP
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I understand that any services I receive are to be held confidential by my therapist and Family Pinnacle, LLC unless I authorize the release of specific information in writing. I understand that this is my right and that my therapist is obligated to protect this on my behalf except under certain circumstances. I understand that a therapist-client relationship exists between myself (or child) and a psychologist affiliated with this practice. I assume final responsibility for all financial obligations associated with any services I receive and that the final responsibility does not fall upon my insurance company or other third party. Payment for services is due at the time of services unless other arrangements are made.

Signature

Date