**Libby Fischer-Osborne, LPC**
**LFO Counseling, PLLC**

**6750 Hillcrest Plaza Drive, Suite 304**
**Dallas, TX 75230**
**214.288.9241**

## Client Information

Name: ________________________________________________ DOB: ____________________

Address: ________________________________ City________________ State_______ Zip__________

Home Phone: _________________ Cell: _________________ E-mail __________________________

Permission for Libby Fischer-Osborne, LPC to contact you is given and the means of being contact is by:
(please check all that apply) _____ Home phone _____ Home address _____ cell phone _____ text _____e-mail

Briefly explain what brought you to counseling? _____________________________________________

Referred by: _______________________________________________________________________

Emergency Contact: _________________________________________________________________

Phone: ___________________________ Relationship to you: ______________________________

Please fill out this section if another party is paying for your counseling sessions. Payment is still required at the time of services.

Person responsible for payment if other than yourself: ________________________________________

Relationship to payee: _____________________ Address of payee: _____________________________

City/state/ zip code: ____________________________ Phone number: _________________________

There may be a need to contact the payee. The payee will be aware of you receiving counseling services. Please sign for permission to contact the payee for reasons regarding payment only. If the payee no longer pays for services, this permission will end.

Signature: ________________________________________ Date: _________________________

1. **All fees are payable on date of service. Payment is accepted by cash, check, Visa/MasterCard credit or debit. <u>A $25.00 fee will be charged for all returned checks. Two or more returned checks or credit card that is processed and decline could result in a cash only arrangement.</u>**
2. **You are responsible to file your own insurance. You are responsible for contacting your insurance company to determine if and how they cover my services as a LPC that is out of network.**
3. **In the event you must cancel, <u>please call within 24 hours prior to appointment time</u> to avoid a <u>fee of $75.00</u>. Calling in advance of a cancellation allows the therapist to open the hour for other clients.**

**Your signature represents your understanding and agreement of all terms above.**

**Client Signature: ____________________________________________ Date:____________________**