Consent For Treatment/ Michael O.L. Seabaugh, Ph.D. (PSY10200)

Name___________________________________

Address:____

Primary Phone: ________________

E-Mail__________________________

DOBirth________________________

Occupation:____

Referred by:____

Reasons for seeking
Psychotherapy:____

____

____

Past Therapy
experience:____

____

IN CASE OF EMERGENCY, PLEASE CONTACT:

____

Phone:____________________
(Name/relationship)

I have read Dr. Seabaugh's Policies and have agreed to enter treatment under the conditions of those terms.

Signature: ____

Date:__________________