

**Alicia R. Camlibel, Ph.D., LPC**

3644 Valley Road  
Liberty Corner, NJ 07938  
(908) 647-1228



**ABOUT THE CLIENT**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Referred by: \_\_\_\_\_

Relevant Medical Conditions (history, current conditions, change in condition) \_\_\_\_\_

Medications (Please include dosage, doctor prescribing medication, and when medication was prescribed):

\_\_\_\_\_  
\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Would you like me to coordinate care with your PCP?  Yes  No

Reason for seeking counseling today? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN CLIENT**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Employer: \_\_\_\_\_

**Consent for Minors**

I authorize my minor child to receive counseling and will participate in family therapy upon request.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**Cancellation and No Show Policy**

If you schedule an appointment and are unable to keep it, you are responsible for calling at least 48 hours in advance to cancel. If this policy is not followed, you will be responsible for paying the total contracted fee. It is the full session. Sudden illness, inclement weather, or other emergencies will be considered on a case-by-case basis.

I have read and understand the above stated policy.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date