



Averill Hovey, MA, MA, LPC, ATR-BC, EMDR
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Client Contact Information

Client's Name: _____ Age: _____ Gender: _____
Race/Ethnicity: _____ Date of Birth: _____

Adult's Name (if client is a minor) _____
Employer: _____ Occupation: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (Home) _____ (Work) _____ (Cell) _____

(circle all numbers above at which you give permission to be contacted)
Okay to leave a voicemail? yes ___ no ___

E-mail address(es): _____

May I add you to my mailing list? Yes ___ No ___

Health Insurance information: Name of insurance _____
Phone number# _____ Policy and/or Member # _____
Group _____

List the preferred way(s) for me to reach you _____

Person(s) to Contact in Case of an Emergency:

1. Name _____
Relationship to you _____
Best way to contact this person _____
2. Name _____
Relationship to you _____
Best way to contact this person _____

I realize that there is a possibility that I may compromise the level of confidentiality when using cell phones and e-mail to communicate. Please indicate by placing your initials next to each means of communication to which you give your consent to use: E-mail _____ Cell phone _____ Cell voicemail _____ (please refrain from texting therapist

except in the case of communicating scheduling changes) I also realize that the contact numbers for Averill Hovey is a Google Voice number_____

Client Signature _____ Date: _____

Parent Signature (if client is a minor)_____ Date: _____

Parent Signature (if dual custody of child)_____ Date: _____