

Mel Gardner, MC, LPC
ph (480) 477-6763
fx (480) 477-5794

14358 N. Frank Lloyd Wright Blvd.,
Suite 3, Scottsdale, AZ 85260

Contact Information

PLEASE PRINT	Date: / /
CLIENT Name:	In Case of Emergency, contact:
Mailing Address:	Name:
City/State/Zip:	phone:
Home# ()	alt. phone:
WK# ()	Relationship:
Cell# ()	
Date of Birth: / /	Age:
Married _____ Single _____	Divorced _____
Referred by:	

RESPONSIBLE PARTY'S Full Name:	
Mailing Address:	
Telephone, Home: ()	
Cell: ()	
Date of Birth: / /	Business ()
Social Security No.:	

If you have Mayo Clinic Insurance, please ask for the insurance form you will need to fill out, and provide your insurance card if you would like us to bill your insurance company for you, otherwise you may request a "superbill" at the time of your appointment and submit your own insurance claims.

MEDICAL	
Previous Therapy: Yes No	Therapist's Name:
	Last Date of Service: / /
Physician's Name:	Therapist's Phone: ()
Date of Last Physical:	Physician's Phone: ()

PAYMENT ARRANGEMENT
Per Session Fee: \$150 initial visit, \$125 additional visits
Paid by Client: by Other:

I agree to the charges specified above. I, also give my permission to Mel Gardner, MC, LPC to coordinate care with the above listed professionals if necessary, for the purpose of my treatment.

Client or Legal Guardian, if Minor

Date