Donna W. Upchurch, Ph.D.

INDIVIDUAL, COUPLE, AND FAMILY THERAPY

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBERS: Home_____ Cell _____

E-MAIL ADDRESS: _____

BIRTHDATE: _____ AGE: _____

EDUCATION: _____ EMPLOYER: _____ PHONE: _____

NAME OF SPOUSE OR RELATIVE: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

ADDITIONAL EMERGENCY CONTACT PERSON: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ RELATIONSHIP:_____

MEDICAL DOCTOR: _____

ADDRESS: _____ PHONE: _____

CURRENT MEDICATION: _____

_____

PREVIOUS THERAPISTS OR COUNSELORS: _____

WHOM MAY I THANK FOR YOUR REFERRAL: _____

FINANCIAL AGREEMENT

The fee for individual, couple, and family therapy sessions or consultations is $150 per 50 minute session due at the beginning of each session. Please make your check payable to: Donna W. Upchurch. A COPY OF YOUR DRIVER'S LICENSE IS REQUIRED. PLEASE TEXT A SCREEN SHOT TO 803-603-4700 PRIOR TO YOUR APPOINTMENT. PLEASE SIGN THIS AGREEMENT.

_____ DATE: _____