Barbara Gold, LCSW, LMFT

14902 Preston Rd. Suite 404-182
Dallas, TX 75254

Psychotherapy Intake Form

Client Name: _____
First Middle Last

DOB:_____ Age:_____ SS#: _____

Gender: _____ Relationship Status: _____

Phone #: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone #: _____

I understand that I am financially responsible for all charges. In the event that insurance is being filed for out-of-network benefits, I hereby authorize Barbara Gold to release all information necessary to secure the payment.

Client Signature: _____ Date: _____