Cristina Lima Therapy
Individual, Couples, and Family
281-770-1779

INFORMED CONSENT

Client's Name: Today's Date:

Date of Birth: Age: Gender:

Name of Parent/Guardian (if client is a minor):

Home Street Address:

City: State: Zip Code:

Cell Phone: May we leave a message? ◯ Yes ◯ No

Other Phone: May we leave a message? ◯ Yes ◯ No

Email: May we email you? ◯ Yes ◯ No

Please note that email correspondence is not considered to be a confidential medium of communication.

Select type of therapy you are looking for: ☐ Individual ☐ Couple ☐ Family

Name of Partner (if Couple's Therapy):

How did you hear about Cristina Lima Therapy?

Emergency Contact Name:

Relationship to Client: Phone Number:

I have read and understood the **HIPAA Notice of Privacy Practices** and the **Clinical Policies**.

I further acknowledge that I seek and consent to therapy with Dr. Cristina Lima.

Signature(s) Date

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