Lisa Kays Psychotherapy
1660 L. Street NW #503, Washington, D.C. 20036
Phone: 202-350-1640; lisa@lisakays.com

Name of Client: _____ Birth date: / /

Email (OPTIONAL: complete only if Lisa Kays may contact you by email): _____

Street Address: _____

Telephone: _____ May leave message at this number: YES NO

Name of Emergency Contact: _____

Emergency Contact Phone: _____

Referred by: _____ Lisa Kays may thank referral source? YES NO

Name and address of person responsible for payment: _____

_____

Telephone: _____

Acknowledgement of Receipt of Client Information Form

I have read the Informed Consent and Client Information, which includes a description of this office's Notice of Privacy Practices and other policies. I have had the opportunity to read and/or discuss its contents with Lisa Kays, LICSW. I understand and agree that the policies stated within, of which I have retained a copy, apply to me. I understand that if I have questions about these policies, I may ask Lisa Kays.

Client, Parent or Guardian signature: _____Date: _____

I understand and agree that I am responsible to pay all charges for services incurred by me.

Client, Parent or Guardian signature: _____Date: _____

OPTIONAL: I would like to save time during my sessions by putting my credit card on file with Lisa Kays PLLC. I understand that doing so will authorize Lisa Kays PLLC to bill me for any missed sessions in addition to sessions I attend. I understand that this is 100% optional.

Authorized signature: _____Date: _____

Please be advised that you may also save time in sessions by paying with a check or using the Instamed HIPAA-compliant portal at any time at: https://pay.instamed.com/lisakays