CONTACT INFORMATION

Printed Name: ____________________ Birthdate: ____________________

Mailing Address: ____________________ ____________________ ____________________ ____________________
Street Address City State Postal Code

This must be an address to which we can send correspondence, as needed. The name "Holistic Mental Health Services Inc." will not be displayed on the envelope.

Home Phone: (______)____________ May a message be left at this number? Yes ☐ No ☐

Cell Phone: (______)____________ May a message be left at this number? Yes ☐ No ☐

Work Phone: (______)____________ May a message be left at this number? Yes ☐ No ☐

Email Address: ____________________

Please Check One of the Following Two Statements:

☐ *I give consent to Holistic Mental Health Services Inc. to use the email above* to correspond with me in all matters directly related to the provision of services (includes invoicing; appointment bookings, confirmations and reminders; follow-up on services; invitations to complete feedback surveys, etc.), with the exception of automatic, system-generated emails if I have opted out of receiving them on page 4 of the Informed Consent. This consent also applies to any new or updated email address that I provide to Holistic Mental Health Services in the future.

☐ *I have not provided my email address in this consent form*, but I understand that if I were to send an email to Holistic Mental Health Services in the future, making an inquiry, I am giving implied consent to Holistic Mental Health Services to respond to that email, as often as needed, in order to address my inquiry.

Would You Like to be on Our Email Newsletter List?(Please Check One of the Statements below):

Our monthly newsletter contains articles on building strong relationships and mental and emotional wellness, links to online resources and book recommendations that you can use to improve your situation, and notices of upcoming workshops or new services.

☐ Yes, I would like to receive monthly email newsletters from Holistic Mental Health Services

☐ No, I do not wish to receive monthly Associates (using the email address above) newsletters

Referral Source:

Please let us know how you learned about Holistic Mental Health Services Inc.

☐ Internet search / website
☐ Another professional (physician, lawyer, etc.)
☐ I am a returning client
☐ Word of mouth (family/friend)
☐ Workshop or seminar
☐ My employer or health insurance provider

☐ Other ____________________

YOUR SIGNATURE ____________________ ____________________
Signature Date