

Shania Chandy, M.A., L.P.C.

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New Client Information

Name: _____ Date of Birth: _____
Address: _____
Social Security Number: _____ Gender: _____ Marital Status: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ Fax number: _____

Please check all that apply, read below, and sign:

I authorize that messages may be left for me or calls may be returned to my:

Home phone _____ Cell phone _____ Work phone _____ Other person answering my phone numbers _____ Email _____

I authorize that I may receive written communication to my:

Email _____ Home address _____ Fax _____

I acknowledge that Shania Chandy MA, LPC may use email, fax, and cellular phone as a means of communication and cannot absolutely guarantee the security of these forms of communication.

Client or Guardian Signature: _____ Date: _____

Employer: _____ Occupation: _____

Student: Yes No School: _____

If dependent child, what is the marital status of the parents? _____ If divorced, according to the divorce decree, who is allowed to seek treatment on the child's behalf? _____

In case of emergency, please notify: _____ at this number _____

Primary Care Physician: _____ Phone: _____

I give permission for Shania Chandy MA, LPC to contact my emergency contact person and/or Primary Care Physician as is necessary.

Client or Guardian Signature: _____ Date: _____

I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Client or Guardian Signature: _____ Date: _____

Financially Responsible Person:

Name: _____ Relationship to Client: _____

Address: _____ Phone: _____

Guarantor Agreement:

I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Shania Chandy MA, LPC.

Signature: _____ Date: _____