DENISE DENICOLO, M.S.
LICENSED PROFESSIONAL COUNSELOR

18534 Forty Six Pkwy, Suite 4
Spring Branch, Texas 78070
(210) 865-6445

CLIENT INFORMATION

Name: ____ DOB: ____________________

Address: ____ City:_____________________

State: ________ Zip: __________ Home phone: _________________ Cell Phone: __________

SS# ________________ Email:____

Place of Employment: ______________________ Driver's License # ________________

Job Title: _______________________________ Business Phone # __________________

Name of Spouse/Partner (guardian of child): ______________________________ D.O.B__________

Place of Employment: ________________________________ Job Title: ______________________

In case of emergency, who should we contact? ____

Phone #: ________________________ Relationship to patient? _____________________________

Party responsible: ____

Referred by: ____

STATEMENT OF UNDERSTANDING / CONSENT

I give my full consent to receiving hypnosis/hypnotherapy sessions by Denise DeNicolo. I understand that results vary and that the above name practitioner may not guarantee results. Hypnosis/Hypnotherapy is not a replacement for medical treatment or psychiatric services.

I understand that the practitioner is a facilitator of hypnosis or hypnotherapy. I am aware and understand that in some cases it may be necessary for the practitioner to respectfully touch my shoulder(s), hand, wrist, or forehead in order to assist me in relaxation. I give the practitioner permission and consent to do so in order to help me establish a beneficial state of hypnosis. I have been advised that I am free to terminate any or all sessions at any time. I have agreed to participate in each session to the best of my ability. I have accurately provided background information as requested by the therapist. I understand that confidentially regarding my sessions will be honored between me and my therapist. This same confidentially is respected when working with minors under the age of eighteen.

Scheduling of Appointments:
Please conscientiously keep all scheduled appointments. If it is necessary to cancel an appointment, you must give at least 24 hours notice. Monday appointments must be canceled before noon on the preceding Friday. **You will be charged $100 for** missed **appointments or appointments canceled without 24 hours advanced notice.** Exceptions to this policy may be made for unforeseen emergencies, but must be discussed on a per case basis with the therapist. If you miss an appointment and do not contact the office about the reason, your next

appointment is automatically cancelled. ***If you arrive more than 15 minutes late for your appointment, your session cannot be extended into the next client's time.***

Fee Policy:

Hypnotherapy sessions are 50 minutes ~ $125.

Payment is due at the time of service.

Acceptable payment methods are Cash (exact amount only, please), Check, Master Card and Visa.

Any returned checks are subject to a $40 charge. Should your account be referred for collections, you agree to pay 6% interest plus a *$25* collection fee and reasonable attorney fees and/or court costs.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS.

Patient's Name:____

____ ______________________________

Patient/Guardian Signature Date

____

Print name