JACKIE L STOUT, LLC
Jackie L Stout, LCSW

485 Carlisle Drive
Suite B
Herndon, VA 20170

703.342.4671

Today's Date ___/___/___

CLIENT INFORMATION

Name Last	First	MI	**Marital Status** (Check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow	**Date of Birth** ___/___/___

Street Address	**City**	**State**	**Zip Code**

Occupation ☐ **Grade/Major** ☐ (Check one)	**Employer** ☐ **School** ☐ (Check one)	Check one: ☐ Full time ☐ Part Time

Employer or School Address	**Email**

Home Phone No. ( )	**Cell Phone No.** ( )	**Work Phone No.** ( )

Referred by: ☐ Physician ☐ Psychiatrist ☐ Therapist ☐ Family ☐ Friend ☐ Website ☐ Other _____

Name of Referral: _____

BILLING INFORMATION

Same as Above ☐ Yes ☐ No	**Name**

Street Address	**City**	**State**	**Zip Code**

Home Phone No. ( )	**Cell Phone No.** ( )	**Work Phone No.** ( )

IN CASE OF EMERGENCY

Name of Friend or Relative	Relationship	Home Phone No.	Cell / Work Phone No.

PLEASE REVIEW THE FOLLOWING DOCUMENTS

☐ Practice Policies & Procedures
☐ Client Information Form
☐ Notice of Privacy Practices
☐ Credit Card Authorization Form

I hereby acknowledge that I have received and have been given an opportunity to read copies of all the documents listed above. I agree to all policies, procedures, fees, and payments as stated in these documents. I understand that if I have any questions regarding any of these documents or my rights, I can contact **Jackie L Stout, LCSW**. I attest that all information I have provided is legally accurate to the best of my knowledge.

If the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment on behalf of this individual.

Client Name _____ Guardian Name (if applicable)_____

Signature (Client/Guardian) _____ Date _____

Guardian's Relationship to Client _____