Heather Ensworth, Ph.D.
978-468-2021
Offices in
South Hamilton and Arlington, MA

INTAKE AND CONSENT FORM

Name: _____

Date of Birth: _____ **Place of birth:** _____

Time of birth (if known): _____

Contact Information:
Phone numbers:

Home :_____**Work :**_____

Cell phone: _____ **Email address:** _____

Home address:

_____

_____

Work address:

_____

_____

Please note:
Payment is expected at the time of the visit. Missed appointments or cancellations with less than 24 hours notice may be charged at the regular session fee.

I have received the Privacy and Confidentiality form and consent to therapy with Heather Ensworth, Ph.D. and agree to the above requirements.

Signed: _____