JOHN GOLL, LMFT
Northern Virginia Men's Counseling
www.NorthernVirginiaMensCounseling.com
john@ NorthernVirginiaMensCounseling.com

A. Name _____Age ____ Date of Birth _____
Address _____ Home Phone _____
City _____ Zip _____ Work Phone _____
E-mail_____ Cell Phone _____
Is it OK to leave phone messages? _____ Please circle preferred phone number.

B. Name _____Age____ Date of Birth _____
Address _____ Home Phone _____
City _____ Zip _____ Work Phone _____
E-mail _____ Cell Phone _____
Is it OK to leave phone messages? _____ Please circle preferred phone number.

C. Children _____ Age _____ _____Age ____
_____ Age _____ _____Age ____
_____ Age _____ _____Age ____

D. Referral Source _____

E. Reason for Seeking Counseling _____

F. Previous Therapist _____ Date(s) of Therapy _____

G. Family Physician _____

H. ***In signing this agreement I understand that I/we agree to pay the established fee at the beginning of each counseling session. I/we also have financial responsibility for any counseling session not cancelled 24 hours in advance.*** I/we also consent to the counselor's use of staffing/consultation with appropriate professionals regarding my/our situation with the stipulation that my/our identity will remain anonymous.

I, the undersigned, agree and consent to participate in the mental health services offered and provided by John Goll, LMFT. I understand that I am consenting and agreeing only to those mental health services that the above named provider is qualified to provide within:

(a) the scope of the provider's license, certification and training; or,
(b) the scope of license, certification, and training of those mental health providers directly supervising the services received by the client.

Client's Name: A _____ Date: _____
B _____