

## Updated Individual Client Information

Alyce E. Wellons, LCSW

Post Office Box 2524

Smithfield, North Carolina 27577

Ph: 404-664-3110 Email: alycewellons@hushmail.com

### Contact Information:

NAME: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (MI)

Address: \_\_\_\_\_

By what **name** do you prefer to be called? \_\_\_\_\_

Do you have a preference of what pronouns you go by, if so, which do you prefer? \_\_\_\_\_

Home phone #: \_\_\_\_\_ May I call you at home? \_\_\_\_\_

Work phone #: \_\_\_\_\_ May I call you at work? \_\_\_\_\_

Cell phone #: \_\_\_\_\_ May I call or text your cell? \_\_\_\_\_

Email address: \_\_\_\_\_ May I email you? \_\_\_\_\_

Of the numbers listed above, are there any at which I should not leave a voicemail message? \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### Emergency Contact(s)

Please indicate who should be contacted in case of an emergency (names, relationship, and phone #'s)

\*Completion of this section indicates permission to contact these people should an emergency (as determined by the therapist) arise. If you choose not to complete this section, should an emergency arise, I will contact 911.

Name	Relationship	Phone Number(s)

There may be times in our work together that I feel you need immediate care from a hospital or physician. In these situations, I have the ability to have you evaluated.

By checking, you grant Alyce E. Wellons, LCSW, permission to seek emergency medical care from a hospital or physician if deemed necessary.

In the event that you need to be hospitalized, what is the name of the hospital you would like to be transported? \_\_\_\_\_

Is there anything I have not asked or updated clinical information that is important for me to know in our work together?

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### Policies

- Cancellations are sometimes necessary; any cancellation less than 24-hr notice will be responsible for the full session fee.
- A credit card must be kept on file through Square and will be charged at the time of session.
- My hours are M-Th from 8:00am-6:00pm for sessions, email and phone calls.