NeuroFlex Wellness
Eileen Callahan, PhD
support@neuroflexwellness.com

NEW CLIENT INFORMATION

Name_____
First Last MI

Address_____
Street Apt # City State Zip

Telephone:_____ Email:_____
Circle one: (home/work/cell)

Date of Birth:_____
Emergency contact name, relationship and #: _____
_____
Personal physician name and #:_____

CREDIT CARD INFORMATION

If you would like your sessions to be charged to your Visa, MasterCard, American Express or Discover card, please fill out the following information:

_____ _____ _____
Account Number Name on Card V Code

_____ _____ _____
Cardholder Signature Billing zip code Expiration Date

I understand that payment is due at the time of service. I assume responsibility for all charges rendered for my care and I authorize payment directly to Eileen Callahan, PhD. I understand that no refunds will be given for any reason.

_____
Client signature Date