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**JUDI ADDELSTON, PH. D., LMFT**  
**1928 Proctor Ave. Orlando, Fl. 32817**  
**(407) 492-3348**

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Client(s) Name \_\_\_\_\_

Client(s) SS# \_\_\_\_\_ Client(s) Date of Birth \_\_\_\_\_

Client(s) Address \_\_\_\_\_

Client(s) Phone (cell) \_\_\_\_\_ (home) \_\_\_\_\_

Place of Employment \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Client(s) Email \_\_\_\_\_

Referral Source \_\_\_\_\_

Is it ok to email you? Y N    Is it ok to call you at home? Y N    Cell phone? Y N

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**Statement of Understanding**

I understand that the first office visit is for evaluative purposes and the counselor is not obligated in any way to treat me.

I understand that my participation in services is purely voluntary, and I may withdraw whenever I wish.

I understand that I must cancel an appointment within 24 hours or else be charged for that appointment.

I understand the following are exceptions to client confidentiality as mandated by Florida law:

- a. When there is cause to suspect a child, adolescent, or elder has been, or may be abused.
- b. When there is reasonable cause to believe that you pose risk of imminent harm to yourself.
- c. When there is reasonable cause to believe that you pose risk of imminent harm to another person.
- d. When there is a valid court order compelling records or witness testimony.

Client(s) Signature \_\_\_\_\_ Date \_\_\_\_\_