

**PEGGY L. FERGUSON, PH.D.**  
**TOWN CENTER, 116 W. 7TH, SUITE 211**  
**STILLWATER, OK 74074**  
**405-707-9600**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_ SS# \_\_\_\_\_  
EMAIL (where we can send information about appointments or information regarding counseling) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
INSURANCE CO. \_\_\_\_\_  
POLICY# \_\_\_\_\_ GROUP# \_\_\_\_\_  
INSURANCE CO. ADDRESS \_\_\_\_\_  
ID# \_\_\_\_\_ PERSON INSURED \_\_\_\_\_  
INSURANCE CO. PHONE NUMBERS \_\_\_\_\_  
SUPPLEMENTAL INSURANCE? \_\_\_\_\_ POLICY # & COMPANY \_\_\_\_\_

**I give my permission to release to the following person(s), dates of service, charges, diagnostic impressions, agreement to pay form, and any other information necessary to bill and receive payment for services:**

**Name of responsible party:** \_\_\_\_\_  
**Address of responsible party:** \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Client Signature**

**In case of emergency any kind of, you may contact the following people:**

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ PHONE (Hm) \_\_\_\_\_  
PHONE (Wk) \_\_\_\_\_ PHONE (Cell) \_\_\_\_\_

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ PHONE (Hm) \_\_\_\_\_  
PHONE (Wk) \_\_\_\_\_ PHONE (Cell) \_\_\_\_\_

\_\_\_\_\_  
Client

You may send emails to the email address listed above.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Revised Date: 2016