



"I never lose, I either win, or learn"
— Nelson Mandela

"The Brain Always Wins"
— John Sullivan

Date	Referral Source		
Name			
Birth Date			
Age			
Occupation/Sport			
Marital Status			
Address			
City			
Zip			
Phone/Text			
Email			
Emergency?	Name	Relationship	Number

If the client is a minor, or someone other is responsible for payment, please fill in the following

Name of financially responsible party		
Address responsible party		
Payment VISA <input type="checkbox"/> Mastercard <input type="checkbox"/> Other <input type="checkbox"/>		
Name exactly as on Card		
Number	Exp Date	Security Code
Billing address if different		

Credit card charges will appear as Square.com or Professionalcharges.com

My signature below indicates consent to such care and treatment as Dr. Pillow considers necessary for improving my mental skills related to sport/performance and any life adjustment issues noted and agreed upon. Also, I have been offered a copy of the 2004 Notice of privacy practices (HIPAA). I understand that this work is not medical and is not covered by health insurance unless it is determined that a mental health diagnosis does exist, which at time, Dr. Pillow will discuss with me the process and procedures that would then be necessary for treatment.

I accept full responsibility for payment at the time of the visit via cash, check, or credit card. I also understand that to protect privacy and confidentiality, Dr. Pillow does not engage with clients on social media.

Signature:

Date: