

Marisa Nava, Ph.D.
Licensed Clinical Psychologist

Client Registration Form
Co-Parenting/Child Specialist Sessions

Date _____

Mother's First Name _____ Last Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Cell) _____
Email address: _____

Father's First Name _____ Last Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Cell) _____
Email address: _____

Child 1 Name: _____ Birthdate ____/____/____ Age _____ Grade _____
School _____ Gender __F__M

Child 2 Name: _____ Birthdate ____/____/____ Age _____ Grade _____
School _____ Gender __F__M

Child 3 Name: _____ Birthdate ____/____/____ Age _____ Grade _____
School _____ Gender __F__M

Child 4 Name: _____ Birthdate ____/____/____ Age _____ Grade _____
School _____ Gender __F__M

Please use the reverse side if needed to add additional information about children.

Payment Information

Individual/Individuals Responsible for Payment _____

Signature of Individual/Individuals Responsible for Payment **X** _____

(Must be signed for services to begin) **X** _____

If more than one person responsible please put percentage of cost each individual will cover.

Credit Card Information:

Cash and personal checks are welcomed, but many clients find it convenient and preferable to allow this office to hold on file a credit card to facilitate transactions; it will provide you with a monthly record of expenditures.

Type: ___ Visa ___ Mastercard ___ Discover ___ AMEX

Card Number: _____ Expiration Date: _____

Name on Card: _____

Type: ___ Visa ___ Mastercard ___ Discover ___ AMEX

Card Number: _____ Expiration Date: _____

Name on Card: _____