Becky Stidham, LCSW
Psychotherapist

ADDRESS: 1510 STUART STREET, HOUSTON, 77004

Client Name: _____ Date of Appointment _____

Home Address: _____ City/State/Zip: _____

Phone Number: _____ Age: _____

Email Address: _____

Place of Employment/School: _____

Occupation: _____

Whom may we thank for referring you: _____

Please briefly detail what problem(s) you would like to address? _____

_____

Goals for Treatment: _____

_____

What significant life changes or stressful events have your experienced lately? _____

_____

POLICIES: Payment is due at time of service. The time allotted for your therapy begins at the time of your scheduled appointment, regardless of your arrival time. A 24-hour notification prior to scheduled appointments is required. If you fail to give 24 hours notice and/or fail to appear for a session, you will be charged $50. Note: Monday appointments require a cancellation the preceding Friday. There are NO exceptions.

__X_____

I am consenting to treatment for myself or my child. I agree to the above policies. Please Type Name.

Midtown
Houston, TX 77004

713.666.0710
Becky@BeckyStidham.com