



Melinda M. Sorensson, Ph.D.
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Client Data & Coaching Terms of Agreement

Please complete this agreement, review the terms, sign & fax to 337 988 5597 along with your completed credit authorization. Thank you!

CLIENT DATA:

Client Name _____

Address _____

Day Phone _____

Evening _____

Fax _____

Email _____

Children (Names & Ages) _____

Partner's Name _____

Birthday _____

Occupation/Employer _____

COACHING TERMS:

Fees: _____ for _____ sessions per month

Duration of session: approx. _____ minutes per session

Session Day: Monday Tuesday Wednesday Thursday Friday

Session Time: am pm PT MT CT ET other _____

Procedures:

Call [your phone number here] for our sessions.

If you call in and get my voice mail, please call back after one full minute.

Please do not leave a message and wait for me to call you back.

I understand that my coach, *Melinda M. Sorensson* is not a licensed therapist and that I am responsible for all my decisions, actions and feelings.

Client Signature/ Date _____