

Introspective Alliance, LLC  
127 South 3rd Street  
Perkasie, PA 18944

Client Information and Consent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email: \_\_\_\_\_

DOB: \_\_\_\_\_

Please briefly describe your reason for seeking therapy at this time:

Client signature indicates consent to treatment with Introspective Alliance, LLC.

\_\_\_\_\_

Client Signature and Date

\_\_\_\_\_

Elizabeth Otto, LPC