Valerie Andersen, Psy.D.
Licensed Psychologist PY9730
Certified Accelerated Resolution Therapist (ART)

Consent to Leave Messages

Name: _____ Date of Birth: _____ Age: _____

Phone number: _____ Email Address: _____

Guardian Name *(if client is a minor):* _____

Do you give Dr. Valerie Andersen, PSYD. permission to leave messages for you regarding appointment scheduling? *(circle)* Yes / No

If yes, how would you prefer to receive messages? *(circle)*

voicemail message / email / text message / message left with someone else

If you prefer a message be left with someone else, please provide their name:

Name: _____ Relationship to client: _____

If you consent to the above, which numbers or email addresses would you prefer?

Home phone: _____

Cell phone: _____

Email: _____

Work / Other *(please specify):* _____

Signature / Signature of Guardian: _____ Date: _____