NEW PATIENT INFORMATION

❖ PERSONAL INFORMATION

Patient Name _____ **Social Security #** _____ - _____ - _____

Home Address _____ **Birthdate** _____ / _____ / _____

City _____ **State** _____ **Zip Code** _____

Telephone (Home) _____ **Telephone (Work)** _____

❖ EMPLOYMENT

Employer (or School) _____

Address _____

City _____ **State** _____ **Zip Code** _____

❖ INSURANCE INFORMATION

Person Responsible for Payment _____ **Insurance?** □ **Yes** □ **No**

Insured Name _____ **Insured Social Security #** _____ - _____ - _____

Relationship to Insured □ **Self** □ **Spouse** □ **Child** □ **Other** _____

Employer _____

Insurance Company _____

Plan _____ **ID#** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Telephone _____

❖ EMERGENCY INFORMATION

Primary Care Physician _____ **Telephone** _____

Person to Contact in an Emergency _____ **Relationship** _____

Telephone _____

Referred By _____

FEE AND CANCELLATION POLICY

A 24 hour notice is required to reschedule your session. Failure to give 24 hour notice will result in a full session charge. Please understand that insurance companies do not reimburse for missed sessions and *YOU ARE ULTIMATELY RESPONSIBLE FOR ALL PAYMENT.*

CLIENT AGREEMENT

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and certify the information I have provided is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient (or Representative) **Date**