DATE_____

CLIENT INFORMATION
(Child-Adolescent)

Name_____ DOB_____

Address_____ City, State, Zip Code_____

Home Phone #_____ SS #_____

School Teacher_____

FATHER/LEGAL GUARDIAN INFORMATION

Name_____ DOB_____

Address_____ City, State, Zip Code_____

Home Phone #_____ SS #_____

Employer_____ Occupation_____

Employer Address_____

Employer Phone # _____ Date Retired_____(if retired)

MOTHER/LEGAL GUARDIAN INFORMATION

Name_____ DOB_____

Address_____ City, State, Zip Code_____

Home Phone #_____ SS #_____

Employer_____ Occupation_____

Employer Address_____

Employer Phone # _____ Date Retired_____(if retired)

HOUSEHOLD MEMBERS

Name	Sex	Age	Relationship	Education

OTHER INFORMATION

Family Physician_____ Phone #_____

Address_____

Referred By_____

Office policy is for payment at time of service unless other arrangements were made.
A 24-hour notice of cancellation is required.

RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the psychologist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance and any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Primary Insurance Co._____**Phone#**_____

Effective Date_____ ID#_____ Group #_____

Subscriber_____ Relationship to Subscriber_____

Subscriber's DOB_____ Employer's Name_____

Secondary Insurance Co. _____Phone#_____

Effective Date_____ ID#_____ Group #_____

Subscriber _____ Relation to Subscriber_____

Subscriber's DOB_____ Employer's Name_____

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

Release of Information

I authorize the release of all psychological information necessary to process all claims and that is pertinent to my health care. I assign all health benefits, including major medical benefits to which I am entitled, to Gary Friedman, PhD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Office Policy

Payment is due at time of service, unless prior arrangements were made. A 1.5 % interest will be added to all outstanding charges (90 days old). Lack of payment could result in termination of services. A 24-hour cancellation notice is requested to avoid a charge of ½ the cost of the appointment. If you missed two (2) consecutive appointments by either No Show or Late Cancellation, your case may be closed and your therapist will refer you elsewhere.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Client Signature:_____ Date:_____

Parent Signature:_____Date:_____

(if client is a minor)