Date:___________________

CLIENT INFORMATION
Child/adolescent

Name:____DOB:_______________________

Address:_________________________City, State, Zip Code:_______________________

Home Phone #:____________________Cell Phone #:____________________________

Guidance Counselor:______________________SS# (of client):____________________

Referred By:______________________________

Father/Legal Guardian Information

Name:____DOB:_______________________

Address:_________________________City, State, Zip Code:_______________________

Phone # (indicate type):_______________________SS#:__________________________

Employer:___________________________________Occupation:____________________

Employer address:__________________City, State, Zip Code:______________________

Employer Phone #:________________________

Mother/Legal Guardian Information

Name:____DOB:_______________________

Address:_________________________City, State, Zip Code:_______________________

Phone # (indicate type):_______________________SS#:__________________________

Employer:___________________________________Occupation:____________________

Employer address:__________________City, State, Zip Code:______________________

Employer Phone #:________________________

HOUSEHOLD MEMBERS

NAME	Sex	Age	Relationship	Education

OTHER INFORMATION

Client Physician:______________________________Phone #:______________________

Address:______________________________City, State, Zip Code:___________________

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 therapist 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/or 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:___________________________Relationship 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 Freidman, Ph.D and/or Roseanne Myers, MS, LPC. 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 (cash, check or charge), unless prior arrangements were made. Any outstanding charges (older than 30 days) will be subject to a $10 late fee in addition to a re-billing fee. In addition, 4% interest will be added to all outstanding charges (60 days old). Lack of payment could result in termination of services as well as being sent to collections. A 24-hour cancellation notice is requested to avoid a charge of 1/2 the cost of the appointment. If you miss 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)