

New Client Information

Last Name: _____ First Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Home Ph.: _____ Cell Ph.: _____
Date of Birth: _____ Age: _____ Ethnicity: _____ Driver's Lic. #: _____
Soc. Security #: _____ Occupation: _____ Employer: _____
Work Ph.: _____ Employer's Address: _____
May Dr. Struhl identify herself when she leaves a message at your home? Yes: _____ No: _____ Work? Yes: _____ No: _____
In Emergency Contact: _____ Phone: _____
Relationship Status: _____ Name of Partner: _____
Name/ Address of Nearest Relative: _____ Phone: _____
Referral Source: _____ Previous Therapist: _____ State: _____ Date of last visit: _____
If you received previous therapy, was your experience positive? Yes: _____ No: _____ Please give brief details: _____

Cancellation and Financial Agreement

I understand that notices of cancellation must be given at least by 5:00 p.m. of the business day prior to the scheduled day of appointment. Otherwise, I will be charged my full fee (not just my co-pay) for the missed session. I also agree that any outstanding balance of my bill will be paid in full with postdated checks at the end of my work with Dr. Struhl. In the event that it is necessary to commence proceedings to collect money due and owing for services rendered, I agree to pay reasonable collection costs and fees incurred including, but not limited to, attorney's fees.

Signature: _____ Date: _____

Health Insurance Coverage

Is pre-authorization required by your insurance company? Yes: _____ No: _____ If yes, have you made the necessary phone call? Yes: _____ No: _____ You will be responsible for any allowable balance not covered by your insurance.

Insurance. Co. Name: _____ Name of Insured: _____

Insurance Company Address: _____ City: _____ State: _____

Zip: _____ Insurance Company Phone: _____ I.D.#: _____ Group#: _____

Authorization to Release Information

I hereby give Dr. Struhl authorization to release/receive information to/from my insurance company by fax, phone, or electronically. Information will be limited to facts relevant to reimbursement only.

Signature: _____ Date: _____

