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 Policy 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 my appointment. Otherwise, I will be charged my full fee (not just my co-pay) for the missed session. 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.

Your 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: _____

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