Laura Struhl, Ph.D.
Licensed Psychologist #PSY12173
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858-694-0057
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New Client Information

Last Name: _____ First Name: _____ Pronouns: _____ 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: _____

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 cancellation notices must be given at least by 5:00 p.m. of the business day prior to the scheduled 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 at the end of my work with Dr. Struhl. If 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

Does your insurance company require pre-authorization? 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 company 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: _____