Summit Psychological Services

| Office Use Only |
| --- |
| Th: _____ |
| Dx: _____ |

# NEW CLIENT INFORMATION

CLIENT NAME_____BIRTHDATE_____/_____/_____

HOME ADDRESS _____ SOC SEC # _____

CITY_____ STATE _____ ZIP CODE_____

PHONE HOME: _____ CELL **(PATIENT)**: _____

BUSINESS: _____ CELL **(PARENT/GUARDIAN)**: _____

EMPLOYER or SCHOOL NAME _____

CITY/STATE _____ OCCUPATION _____

REFERRED BY (HOW DID YOU HEAR ABOUT US?) _____

*PERSON RESPONSIBLE FOR PAYMENT*_____

ADDRESS *(IF DIFFERENT THAN ABOVE)*_____

CITY_____ STATE_____ ZIP CODE_____ PHONE_____

*MEDICAL INSURANCE* ☐ *YES* ☐ *NO* *INSURED'S NAME:* ***(POLICY HOLDER)***_____

*CLIENT'S RELATIONSHIP TO INSURED:* ☐ *SELF* ☐ *SPOUSE* ☐ *CHILD* *OTHER:*_____

*INSURED'S SOC SEC #*_____ *INSURED'S DATE OF BIRTH*_____

*EMPLOYER* _____

*INSURANCE COMPANY*_____ *PLAN*_____ *ID#*_____

*ADDITIONAL INSURANCE?* ☐ *YES* ☐ *NO* *SPECIFY:* _____ *ID#*_____

PERSON TO CONTACT IN AN EMERGENCY _____

RELATIONSHIP_____ PHONE_____

PRIMARY CARE PHYSICIAN_____ PHONE _____

## ♦ FEE & CANCELLATION POLICY ♦

A **24 hour** notice is required to reschedule the weekly session(s) without charge.

## ♦♦ CLIENT AGREEMENT ♦♦

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and certify the information I have provided is true and correct to the best of my knowledge.

SIGNED _____ DATE _____

*(Client or Parent/Guardian if Client is a Minor)*