Emily E. Brislin, PsyD
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New Client Contact Sheet:

Client Name: _________________________ Date:_____________________

Address:_____________________________ Date of Birth:______________

_____________________________________ Age:_____ Sex:__________

_____________________________________ Marital Status:______________

Phone: (home) ________________________ Ok to leave message? Yes ___ No ____

(cell)___________________________ Ok to leave message? Yes ___ No ____

Emergency Contact: _________________________ Phone: ________________________

Relationship to Patient: _______________________

Place of Employment:____

Occupation:____

Referred by:____

Insurance Carrier:____

ID#___________________________________ Co-pay Amount:_________________

Name of Insured (if spouse or parent):__________________________Date of Birth:_______

Secondary Insurance (if applicable): __________________________ ID#___________________

Please read and sign: I understand and agree that I am responsible for all charges not covered by my health plan(s), and agree to pay the known non-covered charges and copayments at the time services are rendered. I grant permission to release the needed medical information for insurance purposes, and authorize payment of health insurance directly to my provider. I certify that this information is true and correct to the best of my knowledge. I will notify Dr. Brislin of any changes in my health status or the above information.

____________________________________ ________________

Signature of Responsible Party Date