David Goodman, Ph.D.
Psychologist Associates

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Returning Client information—Part 1

Name: ______________________________ Date of Birth:__________

Street Address: ____

City, State, Zip: ____

Gender: _____ Marital status: __________ SSN: _________________

Work Status: ❑Employed ❑Unemployed ❑ Retired ❑ Student

Employer or school: ____

Name(s) of parent/guardian for minors: ___________________________

Preferred phone: ____________________ ❑ Cell ❑ Home ❑ Work ❑ Other

May we leave voice messages on this phone? ❑ Yes ❑ No
Would you like text reminders sent to this phone? ❑ Yes ❑ No

Alt. phone: ___________________ ❑ Cell ❑ Home ❑ Work ❑ Other

May we leave a voice message on this phone? ❑ Yes ❑ No
Would you like text reminders sent to this phone? ❑ Yes ❑ No

Email address: _________________________ Circle One: Patient/Parent

By sharing this email address, I agree that I understand that David Goodman Psychologist Associates confirms appointments via email and may send reminders and other appointment-related communications via email.

Are there changes in your insurance?

❑ Yes: Please fill out Part 2, 3 & 4 after signing below
❑ No: Please fill out Part 4 after signing below

______________________________ ________________
Client's Signature Date

______________________________ ________________
Signature of responsible party (If different than client) Date

Insured information—Part 2

Patient relationship to insured: ❑ Self (Skip to Part 3) ❑ Spouse/Partner ❑ Child

Insured's name: ______________________________ Date of Birth: ______________

Address: ______________________ City, State, Zip: ______________________

Work Status: ❑Employed ❑Unemployed ❑ Retired ❑ Student

Employer & address or school: ______________________________________

Phone: ______________________ Email: ______________________________

Insurance information—Part 3

Insurance Co.: ______________________ Plan name: ______________________

Address: ___________________________ Phone: __________________________

Member ID #: _______________________ Group #: _________________________

For Your Review and Consent—Part 4

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: (1) Conduct, plan and direct my treatment; (2) Obtain payment from third-party payers.

I am aware that the Notice of Privacy Practices is posted on your web site and in your office for my review of a more complete description of the uses and disclosures of my health insurance. I have been given the right to review this notice prior to signing this consent. I understand that David Goodman, Ph.D., Psychologist Associates has the right to change its Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

I understand that although insurance may pay a portion of the cost of the professional services received in this office, I am ultimately responsible for the charges. I will pay at the session or follow another payment plan negotiated with the practice manager.

I agree should collection action become necessary for recovery of any monies due under this contact, I agree to pay any and all collection costs, court costs, and reasonable attorney fees.

I understand that should I, at any time during the course of my treatment, need to cancel or change an appointment time, I will need to do so 24 hours prior to the appointment time, unless an emergency situation arises, or I will be charged the full fee for the missed appointment, since it has been reserved for me and, without sufficient notice, is unavailable to anyone else.

By signing below, I agree I have read and agree to the above.

______________________________ ______________________

Signature Date

______________________________ ______________________

Signature of responsible party (If different than client) Date