

RENELLE MASSEY, PH.D. Licensed Psychologist
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CLIENT INFORMATION

NAME _____ BIRTHDATE _____

ADDRESS _____ SOC.SEC.# _____

_____ HOME PHONE _____

REFERRED BY _____ CELL PHONE _____

EDUCATION LEVEL _____ EMPLOYER OR SCHOOL _____

POSITION AND # OF YEARS _____

WORK OR SCHOOL ADDRESS _____ WORK PHONE _____

PERSON RESPONSIBLE FOR BILLS _____ RELATIONSHIP TO RESPONSIBLE PARTY _____

NAME OF INSURED _____ INSURED'S BIRTHDATE _____

INSURANCE _____ GROUP # _____

PHONE # OF INSURANCE CO. _____ SUBSCRIBER # _____

HEALTH CONCERNS & MEDICATIONS _____

EMERGENCY CONTACT PERSON _____ RELATIONSHIP TO EMERGENCY CONTACT _____

PHONE #'s FOR EMERGENCY: HOME _____ WORK _____

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I hereby authorize Dr. Massey to provide psychological services to myself and/or the minor in my custody.

NAME SIGNATURE DATE

I hereby authorize Dr. Massey to bill my insurance company for services provided.

NAME SIGNATURE DATE

I agree that I, or the agency I represent, am responsible for bills not paid by the insurance company.

NAME SIGNATURE DATE

I HAVE BEEN INFORMED THAT I AM RESPONSIBLE FOR FEES FOR SESSIONS NOT CANCELED 48 HOURS IN ADVANCE.

NAME SIGNATURE DATE