*Deborah Wagner, Ph.D., LLC.*
*Licensed Psychologist*
1172 E. Ridgewood Avenue, Suite #2
Ridgewood, NJ 07450

## Welcome to Our Office

**Today's Date:**

PATIENT INFORMATION

Name ______ Sex ☐ Female ☐ Male Birth Date ______.

Address ______ City ______ State ______ Zip ______.

Home Phone ______ Cell Phone ______ Email Address ______.

If child, parent's or guardian's name ______.

Social Security Number ______ Occupation ______ Driver's License ______.

Name of Employer ______ Address ______ Business Phone ______.

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced Personal Status ☐ Employed Full-Time ☐ Full-Time Student ☐ Employed Part-Time ☐ Part-Time Student ☐ Other ______.

Whom do we call in case of emergency? ______ Relationship to Patient ______ Phone ______.

Primary Care Physician's Name ______.

Address ______ City ______ State ______ Zip ______ Phone ______.

Whom may we thank for referring you? ______ Address ______.

**PAYMENT AND INSURANCE INFORMATION**

Subscriber's Name ______ Birth Date ______.

Address ______ City ______ State ______ Zip ______ Home Phone ______.

Social Security Number ______ Occupation ______ Driver's License ______.

Name of Employer ______ Address ______ Business Phone ______.

Insurance Company Name ______ Address ______.

Policy Number ______ Group Number ______

Insurance Plan Name or Program Name ______.

Is Patient's Condition Related To: Employment? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No Other Accident? ☐ Yes ☐ No ______.

Person Financially Responsible for this Account ______ Relationship to Patient ______.

**SPOUSE'S INFORMATION**

Name ______.

Address ______ City ______ State ______ Zip ______ Home Phone ______.

Social Security Number ______ Occupation ______ Driver's License ______.

Name of Employer ______ Address ______ Business Phone ______.

**(over please)**

**OTHER INSURANCE INFORMATION**

Is there another health benefit plan? ☐ Yes ☐ No

Subscriber's Name Birth Date

Address City State Zip Home Phone

Social Security Number Occupation

Name of Employer Address Business Phone

Insurance Company Name Address

Policy Number Group Number Is it through your employer? ☐ Yes ☐ No

Insurance Plan Name or Program Name

Workmen's Compensation Name of Company

Address of Company Company Phone Treatment Authorized By

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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim.

Signed__________________________________________________________________________Date_________________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the assigned physician or supplier for the services described.

Signed___________________________________________________________________________________________________

I understand that submission of insurance claims does not guarantee payment. I am responsible for all charges and payment, regardless of insurance coverage. I may be subject to interest charges for balances overdue 90 days or more.

Patient, Parent, or Guardian Signature_________________________________________________Date________________________

FOR PARENT"S OF CHILDREN IN THERAPY

As the Guardian or Parent please understand that you do have full legal access to information regarding your child. However, if confidence and trust are to be established in the therapeutic relationship, it is necessary to waive this right. This waiver does not include information as to progress made in therapy or in cases where your child is in danger of hurting himself/herself or others. Additional exceptions to the rule of confidentiality will be discussed at the time of appointment.

I agree to these terms.

Parent/Guardian__________________________________________________________________Date_________________________