Registration

Client's name_____
First Middle Last
Home address_____
Street
_____
City State Zip

Date of Birth_____ Age____ Sex___ Marital status_____

Home phone_____ Work phone_____
Cell phone _____
Employer_____
Work address_____
E-mail address (optional)_____

Spouse_____
Spouse's employer_____
Souse's work address_____

Financially responsible person (if other than yourself)
_____
Name Address
_____
Phone

Who referred you for services? _____

Primary Care Physician_____
_____
Address Phone

Previous mental health care:_____
Provider or facility's name

Medications presently being taken, with dosages_____
_____

Current medical problems_____

Health care plan name_____
Address:_____
_____
ID#_____ Group#_____Subscriber_____
Client's SS#:_____

Other plans covering you?_____

Read and sign if using health care plan to help pay for these services:

I,_____, authorize David L. Kupfer, Ph.D. to apply for benefits on my behalf for services rendered. I request that payment be made either directly to David L. Kupfer, Ph.D., if he is an in-network provider, or to me if he is not. I certify that the information provided regarding health care coverage is accurate. I authorize release of any necessary information to my health care plan to enable payment of claims. A copy of this authorization and assignment agreement can be used and considered valid. This will remain in effect until revoked by me in writing. I understand that I am legally responsible for all charges, whether or not paid by my health care plan. While Dr. Kupfer's office may file for payment from certain health care plans, I understand that I am still responsible for full payment of my fees and for understanding my coverage. If Dr. Kupfer's office does not file for payment from my health care plan, I understand that I can send in his Statement for Professional Services (accompanied by a claim form) to my health care plan for them to reimburse me for payment I have made to his office. I understand that the content of our discussions will remain totally confidential unless I give written permission for the release of such information.

Signature_____ Date_____

For all clients to read and sign:

Payment is expected at the time of the session. If I wish to make other arrangements for payment, I am aware that I must talk to Dr. Kupfer about it in advance.

Twenty-four hours notice is requested when I have to cancel an appointment. Dr. Kupfer reserves the right to bill me for the entire cost of the scheduled session for any scheduled session that I miss or cancel with less than 24 hours notice. I understand that my health care plan will not pay for these charges.

I agree to assume responsibility for all charges incurred should collection of this balance become necessary, including court costs, 12% annual interest accrual, and attorney fees. I also understand that I will be charged $25.00 for any checks returned by the bank.

Since I have begun therapy to work towards an important goal, I agree that deciding to end therapy is a decision to be made through consultation with my therapist. When I feel like ending our therapy sessions, I agree to talk to my therapist about it in a scheduled session.

_____ _____

Client or responsible party Date

_____ _____

Therapist Date