Dr. Jack Singer, Ph.D., Licensed Clinical Psychologist, Sport Psychologist, Marriage, Family & Relationship Therapist, Professional Speaker

Psychologically Speaking with Dr. Jack Singer, LLC

NEW PATIENT INFORMATION SHEET

Instructions

1. Print form (2 pages)
2. Fill in information
3. Bring to first appointment with Dr. Jack Singer **OR**
4. Fax to 949-481-5027 if your appointment is a phone consultation

**Dr. Jack Singer, Ph.D., Licensed Clinical Psychologist, Sport Psychologist,
Marriage, Family & Relationship Therapist, Professional Speaker**

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NEW PATIENT INFORMATION SHEET FOR ADULTS

Date: _____ Name:_____Age:_____ Sex:_____

Address:_____City:_____State: ____ Zip:_____

Home Phone:(___)_____ Cell Phone:(___)_____ Referred By:_____

Email: _____Marital Status:_____

Your Occupation:_____ Employer:_____

Business Phone:(___)_____

Spouse's Name:_____Spouse's Employer:_____

Spouse's Business Phone:(___)_____Spouses's Cell Phone:(___)_____

Family Physician:_____Phone: (___)_____

Problem(s) You Want to Resolve:

_____

_____

_____

_____

Emergency Contact:_____Phone:(___)_____

Living in Your Home:

Name:_____Age____Relationship:_____

Name:_____Age____Relationship:_____

Name:_____Age____Relationship:_____

Name:_____Age____Relationship:_____

Name:_____Age____Relationship:_____

Dr. Jack Singer, Ph.D., Licensed Clinical Psychologist, Sport Psychologist, Marriage, Family & Relationship Therapist, Professional Speaker

I understand that I am directly and fully responsible to Dr. Jack Singer for all services rendered to me and/or members of my family by Dr. Jack Singer.

Dr. Singer has explained that his fee is $150/half hour and $285 per full hour and he pro-rates fees for other amounts of time. I further understand that payment is expected when services are rendered and is not contingent on any settlement, judgment or insurance payment, which I may eventually receive.

Dr. Singer will provide me with receipts, which I can file with my insurance company for reimbursement consideration.

Your Signature:_____ Date:_____

Credit Card Payment

If you wish to use a Master Card or Visa for payment, please write your card number below. We will absolutely keep the number confidential.

Master Card ___ Visa ___ (check one)

Credit Card Number: _____Expiration:_____

3 Digit Security code # on reverse of credit card: _____

Is this card billed to your home address? Yes_____No_____If not, please give us the address to which it is billed:

Address:_____City: _____State/Zip:_____

I give Dr. Singer permission to charge my MC/Visa for my office and phone visits at $150/half hour or $285/full hour.

Signature: _____ Date Signed:_____

NOTE: It is our policy to charge for telephone consultations lasting more than 5 minutes. The charge will be pro-rated, based $285/hour. Cancelled phone or office appointments with more than 24 hours notice will not be charged, but cancellations with less than 24 hours notice and missed appointments will be charged $95.

I have read the above and understand my responsibilities in each instance.

Patient's Signature:_____(or person responsible for payment)

Date Signed: _____