**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

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NEW PATIENT INFORMATION SHEET FOR MINORS

Athlete's Name: _____Age:_____Sex:_____ DOB:_____

Address: _____City:_____State:_____Zip:_____

Athlete's Home Phone: _____Cell Phone: _____Email:_____

Name of Coach: _____Coach's Phone: _____

Mother's Name:_____Cell Phone:_____

Mother's Occupation: _____Business Phone:_____

Father's Name: _____Cell Phone:_____

Father's Occupation:_____Business Phone:_____

Emergency Contact: _____Phone_____

Reason for seeing Dr. Singer:_____

_____

_____

Goals you and your athlete wish to accomplish as a result of working with Dr. Singer:

1._____

2._____

3._____

I understand that Dr. Singer's fee is $150 for a half hour and $285 for a full hour. I am directly and fully responsible to Dr. Jack Singer for payment for all services rendered to my child, myself and/or other members of my family by Dr. Jack Singer.

I further understand that such payment is expected when services are rendered and is not contingent on any insurance reimbursement. I understand that Dr. Singer will provide me with a receipt for insurance filing, but there is no guarantee that my insurance company will reimburse me.

Parent/Guardian Signature:_____Date: _____

It is understood that communication between an athlete/patient and a psychologist is strictly confidential. If I or my child desires to have any information disclosed to his/her coach, doctor, teachers, etc., it can only be disclosed by signing the authorization below. (You only need to sign below if you desire Dr. Singer to disclose or receive information about your athlete from his/her coach, teacher or doctor.)

This is to authorize Jack Singer, Ph.D. to request and/or release any information regarding

_____to/from:_____

Parent/Guardian 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: _____