Catherine E. Lewis, Psy.D.

Licensed Clinical Psychologist
PSY 22954

CONFIDENTIAL PERSONAL INFORMATION (Please Print)

Today's Date ______________________ Home Phone ___________________________ Cell/Other Phone _____________________

Patient's Name____ Sex: Male Female

Street Address ____ Age ____________

City ____ State __________________ Zip ___________________

Social Security # ___________________________ Driver's License # ________________________ Birthdate __________________

Place of Birth (City/State/Country) ____

Occupation/School ____ Business Phone ____________________________

Your Employer____

Employer's Address ____

City ____ State __________________ Zip ___________________

Marital Status: Single Married Separated Divorced Widowed

Spouse (or Responsible Party) Name: ____ Relationship _______________________

Occupation ____ Business Phone ___________________

Employer ____

Employer Address ____

City ____ State __________________ Zip ___________________

In case of emergency, please notify ____ Relationship _______________________

Address ____ Phone __________________________

Family Physician's Name ____

Address ____ Phone __________________________

Referred by ____

AUTHORIZATION TO TREAT:

I authorize and direct **Catherine Lewis, Psy.D.**, to perform such therapeutic procedures that her professional judgment may indicate to be advisable for my well-being. I understand that no warranty or guarantee is made as to the results of this treatment. **I agree to assume financial responsibility for the regular fee charged for a failed appointment canceled with less than 24 hours notice**.

Date _____________________________________ Signed ____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or mental health benefits, to include major medical benefits to which I am entitled, including government sponsored programs, private insurance, and any other health plans to Catherine E. Lewis, Psy.D. and any third party billing company. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignees to release all information necessary to secure payment.

Date: _________________________________ Signed ____