Eileen Callahan, PhD
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Date_____
Rate_____
DSM_____

NEW PATIENT INFORMATION

Name_____
First Last MI

Address_____
Street Apt # City State Zip

Telephone:_____ Email:_____
Circle one: (home/work/cell)

If Minor: Mother's Name and phone #:_____
Address if different from above:_____
Father's Name and phone #:_____
Address if different from above:_____

SSN#_____ Date of Birth:_____
Emergency contact name, relationship and #:_____
Personal physician name and #:_____

INSURANCE INFORMATION

_____
Primary Insurance: Name Address Telephone
What name is policy under and relationship to patient_____
ID#_____ Group #_____

_____
Secondary Insurance: Name Address Telephone
What name is policy under and relationship to patient_____
ID#_____ Group #_____

CREDIT CARD INFORMATION

If you would like your sessions or co-payments to be charged to your Visa, MasterCard, American Express or Discover card, please fill out the following information:

_____ _____ _____
Account Number Name on Card V Code

_____ _____ _____
Cardholder Signature Billing zip code Expiration Date

I assume responsibility for all charges rendered for my care. I authorize payment directly to Eileen Callahan, PhD and authorize the release of information to any insurer for the purposes of remuneration.

_____
Patient signature Date

_____
Patient's Guardian or Representative signature Relationship