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NEW PATIENT INFORMATION SHEET

NAME_____
LAST FIRST MIDDLE

CELL___ HOME___ OFFICE___ Phone_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

SEX____ DOB_____AGE____MARITAL STATUS_____

EMPLOYER_____ PHONE_____
_____

ADDRESS_____CITY_____ST_____ZIP_____

STUDENT STATUS_____SCHOOL_____

EMERGENCY NAME, ADDRESS AND PHONE_____

REFERRAL SOURCE_____FAMILY PHYSICIAN_____

PSYCHIATRIST_____

I understand that it is my responsibility to file any claim for insurance reimbursement of services rendered by Marty Glass LPC, should I decide to do so.
I understand that FULL PAYMENT of session fee is required for a MISSED APPOINTMENT with Marty Glass LPC if not canceled with AT LEAST 24 HOURS NOTICE.

SIGNED_____ DATE_____
PATIENT or RESPONSIBLE PARTY