ALIZA FELDMAN, PSY.D.

1 Cattano Avenue, Morristown, NJ 07960 (973) 306-4280 www.feldmanpsychology.com

PATIENT INFORMATION

PERSONAL INFORMATION

Date: _____/_____/_____

Name: _____ Date of Birth: _____

Preferred pronoun: ____He ____She _____Other

Parent of Legal Guardian (if under 18):_____

Home Address: _____Social Security #: _____-_____-_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone:_____

May I leave a message? ☐ Yes ☐No May I leave a message? ☐Yes ☐No

Email: _____

EMERGENCY INFORMATION

Emergency Contact: _____Relationship: _____

Cell Phone: _____Other phone: _____

Primary care Physician: _____ Phone: _____

EMPLOYMENT INFORMATION

Employer or School: _____ Occupation: _____

Address: _____ Phone: _____

City: _____ State: _____Zip Code: _____

INSURANCE INFORMATION

Person responsible for payment: _____ Insurance?: __ Yes __No

Insured Name: _____

Insured Social Security # _____--_____--_____ Relationship to insured?: ___Self _____Spouse ____Child

Employer:_____

Insurance Company_____

Plan: _____ ID#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____-

Fee and Cancellation Policy:
Dr. Feldman requests 24-hour notice to cancel or reschedule your appointment. If you do not provide 24-hour notice, you may be charged for the full session fee for the missed appointment. Insurance companies will not reimburse for missed sessions.

Patient Agreement:
I understand and agree that, regardless of my insurance status, *I am ultimately responsible for the balance on my account for any professional services rendered*. I have been provided, read, and understand the Privacy Notice, Therapy Contract, and Informed Consent.

_____ _____

Signature of Patient or Legal Guardian Date