HADDONFIELD PSYCHMANAGEMENT, P.A.
Comprehensive Psychological Services

31 Tanner Street
Haddonfield, New Jersey 08033
Telephone: (856) 428-7646
Fax: (856) 216-1839

PATIENT INFORMATION

Today's Date_______________

Name of Doctor you will be seeing today ___________________________

Patient's Name____________________________________ Parent's/Guardian's Name (*if patient is a child*)_________________________

Patient Birth Date ___/___/___ Current Age________ Gender: M F Marital Status _______ Patient's SS#_________________________

Patient's Address (*Street*)____ *(Apt. #)* _____________

(*City*)____ (*State*) ___________ (*Zip Code*) _____________________

Phone (*Home*)______________________ Cell ______________________ Work # *for:* Patient – Parent - Guardian ______________________
(please circle)

Emergency Contact & Number____

List any major health problems____

Medications you are currently taking ____

Have you ever received *Psychiatric* or *Psychological* services before? Y N

When/For what reason? ____

Referred to this office by______________________________

Primary Physician Name / Address ____ Phone_____________________

(City / State / Zip) ____

PLEASE READ CAREFULLY AND SIGN BELOW

- I authorize the payment of medical benefits for services provided at Haddonfield PsychManagement, P.A.
- I authorize the release of treatment information as required by my insurer to process claims.
- I acknowledge that I am responsible for payments for services that are not covered by my insurer to include deductibles, copayments, or any uncovered costs.
- I understand that copayments are due at the time of the delivery of service and accepted by my provider in their office.
- I understand that if a patient is a minor, copayments are the responsibility of the parent or guardian who accompanies the minor.
- I acknowledge that the establishment of financial arrangements between separated or divorced parents are not the responsibility of Haddonfield PsychManagement, P.A. Such arrangements should be clearly established prior to the provision of services.
- I understand my rights under the HIPPA Compliance Act and that a copy of the Protected Health Information Notice has been provided to me. At any time, I can request information or make inquiry at HPM to expand my understanding of my right to privacy.
- I am aware that there are fees when requesting correspondence, reports, and testing that are not covered by insurance carriers.

(THE SIGNATURE OF THE PATIENT / PARENT / GUARDIAN INDICATES AGREEMENT AND ACCEPTANCE OF THESE CONDITIONS)

Patient____ Date____________________________

Witness____ Date____________________________