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Diplomate in Clinical Psychology
American Board of Professional Psychology

Diplomate in Neuropsychology
American Board of Professional Neuropsychology

CLIENT INFORMATION

YOU HAVE MY PERMISSION TO LEAVE PHONE MESSAGES AND SEND MAIL TO:

Client: _____ Birthdate: _____ Age _____

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Spouse Name: _____

Employer: _____ Social Security #: _____

Referred by: _____

CLIENT GIVES PERMISSION FOR CONTACTING THE FOLLOWING PERSON
IF IN PSYCHOLOGIST'S JUDGMENT SUCH CONTACT IS CONSIDERED NECESSARY

_____
Name Relationship to Client Address Phone

RESPONSIBILITY FOR PAYMENT

I understand that all services are rendered and charged to me and not to a third party or an insurance company. I understand that I am responsible for paying for all services and charges that are not covered or not authorized by an insurance company, including extended sessions, telephone calls, preparation of reports, and any unkept appointments. I understand that I am responsible for paying full charges on all appointments that are unkept, rescheduled, or cancelled with less that 24 hours advance notice to Dr. Doverspike.

I understand and agree that I will pay all fees at the time services are rendered or billed to me. I understand that Dr. Doverspike cannot accept responsibility for collecting or negotiating a settlement on a disputed claim. I hereby accept full and complete responsibility for all debts and obligations during the course of the above-named client's evaluation and/or treatment. For the purpose of collecting debts, I understand and agree that the above information will be released to Nations Recovery Center (NRC) or other collection agency in the event that I do not pay my account within thirty (30) days of services being rendered. I authorize all of the above information, including last date of service and total amount of debt, for the purpose of collecting the debt.

_____
Client's Signature Date