Catherine Kaplan Ph.D., LLC

Registration Form (rev 2/16)

Date:_____

Name_____
Last First MI

Date of Birth: _____ Age: _____ Gender: M F

Address: _____zip +4 _____

Telephone:

Preference order (1-3)		Permission to leave a message? (circle one)
_____	Home: _____	YES NO
_____	Cell: _____	YES NO
_____	Work: _____	YES NO

Email Address: _____

Only provide email if you are o.k. about being contacted via email regarding appointments.

If Couples Therapy: Partner's name and phone: _____

Marital Status: Minor Single Married Divorced Widowed Separated

If Client is a Minor, please provide:

Parent: _____Custodial or Non-custodial (circle one)

Address: _____

Home Phone: _____ Mobile: _____ Work: _____

Parent: _____Custodial or Non-custodial (circle one)

Address: _____

Non-custodial Parent:

Home Phone: _____ Mobile: _____ Work: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____

Phone number(s): _____

Employment: Full-time Part-time Unemployed Disability

Employer Name: _____

Employer Address: _____

Student: Full-time Part-time School/College: _____ Grade/Year _____

Referred by: (circle one): Psychology Today Doctor Friend Other: _____
If I may send a thank you, please provide: Name: _____
Address: _____Phone: _____
Permission to contact: YES NO Signature: _____

Family Doctor: _____ Phone:_____

Address: _____

Responsible Party: _____ DOB ____/_____/_____

Relationship to Client: _____ Social Security Number: _____

Address: _____

Home Phone: _____ Work Phone:_____
Complete below for Medicare or Penn Behavioral Health only. All others are out-of-network:

Insurance Type: _____ Insurance #: _____

THE FOLLOWING MYST BE SIGNED BY ALL CLIENTS, AGE 14 AND OVER. IF CLIENT IS UNDER 14, PARENT MUST SIGN.

For the Client:
My signature below indicates that I have read and understood the office policies of Catherine Kaplan PhD, LLC. I also understand that failure to pay for any services rendered can result in legal action. I give my consent to Catherine Kaplan, PhD, LLC to evaluate and/or treat myself.

Signature: _____ Relationship to client: _____ Date _____

For the Parent/Legal Guardian:
My signature below indicates that I have read and understood the office policies of Catherine Kaplan PhD, LLC. I also understand that failure to pay for any services rendered can result in legal action. I give my consent to Catherine Kaplan, PhD, LLC to evaluate and/or treat my child under the age of 14.

Parent/Guardian Signature: _____ Relationship: _____Date _____