

David E. Loffis, Ph.D.

Name _____ Date _____
Address _____ Apt# _____
City, State, Zip _____
Home Phone (____) _____ Office (____) _____ Cell (____) _____
E-mail _____ Fax (____) _____
Age _____ Date of Birth ____/____/_____

Employer _____

REFERRED BY _____

Family Members Name _____ Age _____
Partner _____
Child _____
Child _____

List a close relative or friend to be notified in case of emergency

Name _____ Phone (____) _____

Is it permissible to call you at home? yes no At work? yes no
May I leave messages on your voicemail? yes no

Please identify the best phone number to leave a message in case of any appointment change or emergency cancellation. Home _____ Office _____ Cell _____

Primary Physician's Name _____
Phone(____) _____

Please describe any physical symptoms or difficulties you are presently experiencing.

Have you consulted a physician about these symptoms? _____

If you are presently taking prescribed medication, please list medication and prescribing physician.

CANCELLATIONS AND BILLING:

Individual sessions are charged at full fee unless you cancel 24 hours in advance. A message left on my voice mail that you wish to cancel your appointment is sufficient.

I prefer that you pay for sessions each time and have your insurance company reimburse you. Please feel free to discuss this policy with me if you have a problem with my payment procedures or need assistance with insurance.

On signing this agreement, you understand that your contract for services is between you and your individual therapist. The presence of other professionals in this office is in no way to be construed as a partnership of responsibility for services or liability, actual or implied. I further acknowledge that I have been given a copy of HIPPA privacy law.

Date _____ Signature _____