Debra Gill Psychological Services 124 East Mount Pleasant Avenue, 2nd Floor Livingston, NJ 07039 (973)820-5174

www.debragill.com

<u>CLIENT INFORMATION:</u>		TODAY'S DATE:		
Name		Mr. Mrs. Ms. Dr. Mino	or	
Address		City		
State	Zip	Home Phone		
Cell Phone#		Date of Birth //		
Email Address(es)			
EMPLOYMENT OF	R STUDENT INFO	RMATION		
Occupation/School	ol level	Full or Part Time	?	
Employer or Scho	ol Name		-	
Work Phone #		Ext Fax #	_	
SPOUSE/PARTNE	R INFO or IF A	MINOR, PARENT INFORMATION		
Marital Status: M	S D W Oth:	Minor lives w/		
Spouse or 1st Par	ent Name:	Best #		
2nd Parent Name	(for Minor):	Best #		
RESPONSIBLE PA If client is not the pa		ON payment, please provide the following informati	on	
Person Responsible		Relationship		
Address		Best #		
Email Address(es)			
Drivers Lic #		Date of Birth /		
Occupation:		Employer:		
Work City	Worl	k Phone # Ext		

PAYMENT INFORMATION

<u>Payment is due at the time of service</u>. Dr. Gill accepts cash, check made out to Debra Gill, or a credit card/flex spending card. Bounced check fees will be charged to the responsible party.

INSURANCE INFORMATION

Primary Insurance Co.

Please call your insurance company to find out your behavioral health deductible and percentage that insurance will pay for <u>out-of-network</u> behavioral health services. Dr. Gill will submit your claims, but cannot guarantee reimbursement. The obligation to pay Dr. Gill's fee rests with the client or Responsible Party listed above regardless of insurance coverage.

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Claims Address (city, zip)	OR "Payor ID"			
Ins. ID#Subscriber's	Name			
Ins. Group # Subscriber's	DOB/			
Patient's relationship to subscriber: Self Spouse Child Other				
REFERRAL INFORMATION (please circle)				
How did you find Dr. Gill? Referral? Website?	Listserve?			
If Website, which? Psychology Today Eating Disorder Hope BEDA Dr. Gill's Website (<u>www.debragill.com</u>) other site				
Referring individual I may thank				
PRIMARY REASON FOR SEEKING TREATMENT				
FINANCIAL CONTRACT AND CANCELLATION POLICY By my signature below, I assume responsibility for all fees incurred. I understand that payment is due at time of session. I understand that I will owe a full session fee for any scheduled session that is missed or not cancelled 36 hours prior to appointment time.				
Signature of Responsible Party	Date			
Signature of Client if not Responsible Party				

Effective Date