Daniel Noll, Ph.D.
NJ Licensed Psychologist #5410
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New Client Registration

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Client Name: ____ DOB: __________________ AGE: ______ SS#: ______________________

Complete Home Address: ____

Cell Phone: ______________________________ Home Phone: ____________________________ Business Phone: ____________________________

Best phone number to reach you (please circle one). Inform me if I shouldn't leave a message at a phone number.

Names of Children and Ages: ____

Names of Siblings and Ages: ____

Names of Parents and Ages: ____

Name of Spouse/Partner and Age: ____ Marital Status: ____________________

Medical/Psychological Diagnoses: ____

Medications: ____ Allergies: ____________________________

Occupation and Employer: ____

School/Year/GPA: ____

Insurance Subscriber's Name or Person Responsible for Payment: ____

Client's Relationship to Insured or Person Responsible for Payment: ____

Insured's Address and Place of Employment, if different from Client's: ____

Insured's SS#, if different from Client's: _____________________________________ Insured's DOB, if different from Client's: __________________

Insurance Company/Plan: ____ ID#/Policy Number: ____

Secondary Insurance/Plan: ____ ID#/Policy Number: ____

I will need to make a copy of your insurance cards and personal identification such as a driver's license for accurate billing.

Primary Care Physician/Address/Phone: ____

Emergency Contact/Relationship/Phone: ____

Referred By/How did you hear about my services: ____

Cancellations and Missed Visits – It is expected that we will meet weekly unless we agree it's clinically appropriate to meet at a different frequency. **All cancellations and missed visits will be billed at $120, *Even If You Give Me Prior Notice Unless Rescheduled That Week*, or if due to the following circumstances – hospitalization, death of a loved one, illness requiring you to stay home, or vacation with advance notice.** I will try to reschedule a cancellation or missed visit in the same week if we can coordinate schedules, but if it is not possible you will be responsible for the cancellation/missed visit charge of $120. Insurance will not pay for these charges. You are held responsible to pay for cancellations and missed visits.

I hereby authorize Dr. Noll to furnish information to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. I understand and agree that I am ultimately financially responsible for the balance on my account for professional services rendered. I have read all the information on this registration form and certify the information I have provided is true and correct to the best of my knowledge.

~Signatures~

Any Client over 14 years: ________________________________ Parent/Guardian: ______________________________ Date: __________________

~Print Names~

Client: _______________________________ Parent/Guardian: ______________________________ Relationship to Client: ____________________
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