

Daniel Noll, Ph.D.

New Client Registration

NJ Licensed Psychologist #5410

202 Raritan Ave., Highland Park, NJ 08904-2446 •Phone: 732-306-9609 •Fax: 732-253-7340

Client Name: _____ D.O.B.: _____ Age: _____

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, if different from Client's: _____

Insured's Place of Employment, if different from Client's: _____ Insured's DOB, if different from Client's: _____

Insurance Company/Plan: _____ ID#/Group Policy Number: _____

Secondary Insurance/Plan: _____ ID#/Group 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 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~

All Clients over 14 years: _____ Parent/Guardian: _____ Date: _____

~Print Names~

Client: _____ Parent/Guardian: _____ Relationship to Client: _____