SARAH DIEHL
THERAPY

New Patient Information

Name ______________________________

Gender __________ Date of Birth ______________

Relationship Status ______________________________

Email ______________________________

Phone *Primary* ________________ *(Home/Cell/Work?)*

Other ________________ *(Home/Cell/Work?)*

Mailing Address ______________________________

____

____

How did you learn about my practice?

____

Please describe your work status — *Use "P" for patient and, if someone else is paying for your treatment, indicate "G" for guarantor.*

☐ Employed, hours/week ______________

____
Name of Employer

____
Annual Gross Income

☐ Unemployed ☐ Disabled

☐ Full-time parent or caregiver

☐ Student or recent graduate (Year ______)

☐ Retired (Year ______)

☐ Other ______________________________

Emergency Contact

If you are engaged in couple's counseling, please provide the requested information for someone other than your partner.

Name ______________________________ Relationship ______________________________

Phone *Primary* ______________________________ *Other* ______________________________

Guarantor

If someone else is guaranteeing payment for treatment, please provide the following information about them and be sure to complete the work status section (above):

Name ______________________________ Relationship ______________________________

Date of Birth ____________ Phone ______________ Email ______________________________

Signature

By your signature, you indicate the following: you have read my Payment and Privacy Practices and had opportunity to ask questions about them, and you agree to pay for treatment and any associated costs and fees. Also, if you are using insurance, your signature indicates your authorization for me to bill the insurance company and release health care information they request.

______________________________ ______________________________
Patient *Date*

______________________________ ______________________________
Guarantor (if not the patient) *Date*