Dx: _____

Amy S. Clark, Psy.D.
P.O. Box 12808
Everett, WA 98206

NEW PATIENT INFORMATION

Client Name:_____Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Telephone:_____Email Address: _____

Employer:_____

Birth Date:_____Age:_____

Name of Significant Other: _____

Referred By: _____

Primary Insurance Company Name and Telephone: _____

Family Physician: _____ Address:_____Phone:_____

Current Medications: _____
_____

- I understand that I am responsible for my bill and will follow the payment option of:
  1. Payment in full at each session._____
  2. Payment as follows:_____
- I authorize release of medical or other information requested by the insurance companies or other third party payers listed above to facilitate claims processing.
- I authorize payment directly to Amy S. Clark, Psy.D.
- I permit a copy of this authorization to be used in place of the original.

Signature:_____
Client Date

Signature:_____
Parent or Guardian Date