Ashley Heintzelman, LLC

Licensed Psychologist

Today's Date ____/____/____

Last Name_____
Last Name First Name Middle Initial

Home Address_____

City, State and Zip Code_____

Home Phone ( ) _____Cell Phone ( ) _____ Mom Work ( ) _____
May we call there? Yes/No May we call there? Yes/No May we call there? Yes/No

Mom Cell ( ) _____ Dad Work ( ) _____ Dad Cell ( ) _____
May we call there? Yes/No May we call there? Yes/No May we call there? Yes/No

E-Mail (Adolescent)_____E-Mail (Parent)_____

Education (grade) _____ School _____

Referred By_____

In Emergency, Notify: (Please name two)

Name _____ Name _____
Address_____ Address_____
_____ _____
Phone_____ Phone_____
Relationship to you_____ Relationship to you_____

Family Physician: _____
Name Phone

_____
Address City State Zip

Your Signature_____ Date____/____/___
(This signature does not authorize release of information or obligate you in any way to Ashley Heintzelman, LLC. It is requested for your protection only)

Parental Consent_____Date____/____/__

***Regarding insurance: It is the responsibility of the client to file claims with their insurance company.
Your Practitioner does not maintain a supply of insurance forms. Payment is required at the time of service.