Palmwood Center for Psychological Services, P.A.
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Alec Roth, Ph.D.	**Jonathan Pearlson, Psy.D.**	**Marlene Gray, Psy.D.**
Licensed Psychologist	**Licensed Psychologist**	**Licensed Psychologist**

CONFIDENTIAL INTAKE

Date:_________________SS#:_______________Referred by:_________________________

Patient Name:____________________Spouse's Name:________________________________

Date of Birth:______________Age:_______ Date of Birth (Spouse):___________Age:____

Address:____

____

Telephone (Patient) Home:______________Telephone(Spouse)Home:_________________
Cell:_____________________Cell:_____________________________
Office:_____________________Office:__________________________
Pt's Occupation:_______________________ Spouse's Occupation:______________________
Names, Ages and Sex of Children:____

Briefly describe your reason for coming here today:__________________________________

List previous psychological and/or psychiatric treatment:
Year   # of Sessions   Therapist

____

Please list all of your current medications:____

____

If minor, please give full name of both parents:_______________________________________

"I recognize, understand and accept that I am ultimately financially responsible for any and all charges for services rendered by the Palmwood Center for Psychological Services, P.A., its employees and/or its officers including, but not limited to, any services or fees not covered or denied by my insurance. I agree to pay all additional charges associated with the costs of collection if my account becomes delinquent, including reasonable attorney's fees, court costs, finance charges and the legal rate of interest on the account until paid in full. I hereby assume financial responsibility for all charges that may be incurred for treatment rendered to myself and/or my family members. Because time has been reserved exclusively for me and/or my family member(s), I understand that I am required to provide at least forty-eight (48) hours advance notice if unable to keep the scheduled appointment. **In the event that I do not provide the forty-eight (48) hours notice prior to canceling, I am financially responsible for the reserved appointment.** I allow you to electronically transmit my data."

Signature of Patient:____