# CAROLYN NOWAKOWSKI, PSY.D

(Please Print)

## PATIENT REGISTRATION SHEET

| Today's Date: | | |
|---|---|---|

## PATIENT INFORMATION

| Last Name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|
| Street Address: | City: | | State: | | ZIP Code: |
| Home phone #: OK to contact? ( ) | Cell phone #: OK to contact? ( ) | Social Security #: | Birth Date: / / | | Sex: ❑ M ❑ F |
| Employer: | Occupation: | | Work phone #: ( ) | | |
| Street Address: | City: | | State: | | ZIP Code: |
| Referring Doctor (if required by insurance): | | | | | |
| Notify Primary Care Physician? ❑ YES ❑ NO | Name of Primary Care Physician | | Contact #: ( ) | | |

## IN CASE OF EMERGENCY

| Emergency Contact Name: | Home phone #: ( ) | Cell phone #: ( ) |
|---|---|---|

## INSURANCE INFORMATION

| Insured's Last Name **(if different):** | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|
| Home phone #: **(if different)** ( ) | Cell/Other contact #: ( ) | Social Security #: | Birth Date: / / | | Sex: ❑ M ❑ F |
| Insurance Company: | Insurance Billing Address: | | Insurance phone #: ( ) | | |
| Policy #: | Group #: | Relationship to Insured: | ❑ Self | ❑ Spouse | ❑ Dependent |

## SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

| Insurance Company: | Insurance Billing Address: | | Insurance phone #: ( ) | | |
|---|---|---|---|---|---|
| Policy #: | Group #: | Relationship to Insured: | ❑ Self | ❑ Spouse | ❑ Dependent |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Carolyn Nowakowski, those acting on the practice's behalf, and my insurance company to release any information required to process my claims.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

*Patient/Guardian signature* *Date*

*** PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged for the session amount. Thank you for your cooperation.**