Healing Hearts Therapy, LLC
From the Office of Robin Newman, PsyD
Licensed Clinical Psychologist
Child and Adult Psychology and Assessment

Client Information

Client's Name _____ Today's Date_____

Birthday_____ Spouse's Name (if married)_____

Email Address_____

Address _____

City, State, Zip Code _____

Home Phone _____ Cell Phone _____

Emergency Contact Name & Number _____

Insurance ID #) _____

Primary reason for seeking treatment today: _____

I agree to pay today for all services provided to me. I also understand that I must give at least 24 hours notice in order to cancel an appointment or I will be billed in full for the missed appointment. In addition, I also understand that if I want Dr. Newman to bill my insurance company and they do not pay, I am liable for all charges not covered by my insurance.

_____ _____

Signature Date