David E Myers, PhD

Licensed Clinical Psychologist

Today's Date: _____ SSN: _____

Name: _____ Date of Birth: _____

Address: _____Zip:_____

Cell: _____ Home: _____ Work: _____

INSURED'S NAME: _____ INSURED'S DOB: _____

Insurance Name: _____

Insurance Contract/ID # _____ Group # _____

_____

SECONDARY Insurance: _____

INSURED'S NAME: _____ INSURED'S DOB: _____

Insurance Contract/ID # _____ Group # _____

I understand that I must give a 24 hour cancellation notice for appointments or I will be responsible for the fee.

I understand that I am responsible for all debts incurred in the therapy process and if collection is necessary, I agree to pay all costs of collection, including reasonable attorney fees plus court costs.

_____ _____

Signature Today's Date