

Matthew Bennett Psy.D.
Licensed Psychologist PSY 21029
805-804-7231

NEW PATIENT FORM

Today's Date _____ Referred By _____

Patient's Name _____ Age _____ DOB _____

Parent or Guardian _____

Address _____

Home Phone _____ Business Phone _____ Cellular Phone _____

Insured's SSN: _____ Drivers Lic. # _____ Marital Status S M W D

Name of Spouse: _____ Insured's Employer: _____

Insurance Carrier: _____ Subscriber's Name: _____

Subscriber's Soc Sec. #: _____ Group/ID#: _____

PAYMENT AND INSURANCE REIMBURSEMENT: Patients are expected to pay for services at the time they are rendered unless other arrangements have been made. Professional services provided to patients who carry insurance will be charged to the patient. Dr. Bennett will provide you with an insurance form, which you may use to submit to your insurance company for reimbursement.

CANCELLATIONS AND EMERGENCIES: Appointments are made in advance. If you are unable to keep your scheduled appointment, please notify the office 24 hours in advance to avoid being charged. Patient's insurance will not be billed for missed/cancelled appointments and the office will bill you directly. If you need to contact Dr. Bennett between sessions, please leave a message with the service 805-804-7231, and your call will be returned.

EMERGENCY CALL: When Dr. Bennett cannot be reached for urgent calls, patients are directed to call 911 or go to the local hospital emergency room.

CONFIDENTIALITY: All information disclosed within session is confidential and may not be revealed to anyone without written permission, except where disclosure is indicated by law. Disclosure may be required in the following situations: when there is information regarding child abuse or neglect or elder abuse; if Dr. Bennett is mandated to do by the Court; when a person is a danger to self, others, or is gravely disabled.

CONSENT FOR TREATMENT: I authorize and request Dr. Bennett to carry out psychological examinations, treatments, and/or diagnostic procedures which now or during the course of my care (or dependent child) as a patient are advisable. I understand that the purpose of these procedures will be explained to me and be subject to my agreement. I have read and fully understand the above information contained in this form.

Signature of Patient: _____ Date _____

Signature of Parent/Guardian/Conservator: _____ Date _____

Dr. Matthew Bennett, Ph.D., Inc.: _____ Date _____

NOTE: Please refer to the PSYCHOTHERAPIST – PATIENT SERVICES AGREEMENT (provided to you by Dr. Bennett, for more in-depth details, fees, confidentiality, insurance and emergency calls).