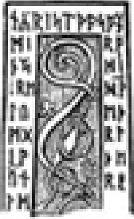


Matthew D Bennett PsyD

Professional Psychology Services

NEW CLIENT FORM

Client Information

Name: ______________________________ Date of Birth: mm/dd/yyyy ____/____/_______ Age: _____

Address: _______________________________ City: _________________ Zip Code: _____________

Phone: (Home) ________________ (Cell)___________________ (Other)_________________________

Email: __________________________________ Name of Spouse (if adult) or Guardian (if minor):

Occupation: _____________________________ ____

How did you find out about us? ____

Insurance Information

Name of insured: ______________________________ Insured SSN: ____________________________

Insurance Carrier: _____________________________ Insured's Employer: ______________________

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.

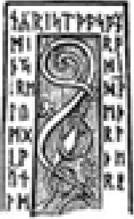
CANCELLATIONS AND EMERGENCIES: Appointments are made in advance. If you are unable to keep your scheduled appointment, please notify Dr. Bennett 24 hours in advance to avoid being charged. <u>Patient's insurance will not be billed for missed/cancelled appointments and the office will bill you directly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

Matthew D Bennett PsyD
Licensed Psychologist California PSY 21019
NPI 1396894242

Telephone (805) 804-7231
Email DrMBennett@gmail.com



NEW CLIENT FORM

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.

Client Signature	Date
Signature of Parent/Guardian/Conservator	Date
Dr. Matthew D. Bennett	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).

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