DRTHALIAMOSHOS
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FEIN# 83-1415619 • MT LICENSE# PSY-PSY-LIC-5075 • PA LICENSE# PS018579 • NPI# 1891353736

Client Information Form

_____ _____
Client Name Date of Birth

_____ _____
Parent/Guardian Name (If Under 18) Phone

_____
Mailing Address

_____ _____
City, State, Zip Email Address

Is it okay to Email for Scheduling Appointments? [ ] Yes [ ] No

Is it okay to leave detailed message on **Primary Phone** ( ) _____-_____? [ ] Yes [ ] No

Okay to leave detailed message on **Alternate Phone** ( ) _____-_____? [ ] Yes [ ] No

_____ _____
Emergency Contact Name Phone

_____
Mailing Address City, State, Zip

_____ _____
Emergency Contact Name Phone

_____
Mailing Address City, State, Zip

By signing below, I agree to the following:

(1) I understand that the client is ultimately responsible for the cost of all services rendered.

(2) I will pay the appropriate fee at the time service is rendered.

(3) I understand that I will be billed for missed appointments that are not cancelled at least 24 hours in advance and that I am responsible for paying those charges.

(4) I agree to pay for all costs of collection of the client's delinquent accounts including reasonable attorney fees.

(5) I agree that if my mailing address is written incorrectly, has changed since the date of this form, or is missing from this form, I may receive a bill at a current and verifiable address for any outstanding charges.

_____ _____

Signature of Client/Guardian Date

_____ _____

Thalia P. Moshos, PsyD Date