**Orna Goldwater, PhD**

18403 Park Grove Lane Dallas. Texas. 75287

**Patient**

|  |  |
| --- | --- |
| Name: Legal | Guardian/Parent: |
| Age: Date of Birth: / | / Place of Birth: |
| Home Address: |  |
| Street  Contact Telephone: ( ) | Apt. Ciiy Stale Zip  [Home] ( ) - [Day Time] |
|  |  |
| Family | |
| Family Members: Mother: | Father: |
| Children: | Age: |
|  | Age: |
| Age: | |
|  | Age: |
|  | Age: |
|  | Age: |
| Other family members living at home: |  |
|  | |

**Presenting Problem**

|  |  |
| --- | --- |
| Briefly description the problem for which you are seeking | therapy/consultation . |
|  | |
|  | |
|  | |
|  | |
|  | |

**Solutions**

|  |  |
| --- | --- |
| Please | Please describe the methods you have previously used to solve this problem. |
|  | |
|  | |
|  | |
|  | |

**Professionals**

If you are seeing other professionals regarding this issue or other health problems, please list them below:

Name City Contact Information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person Responsible for Payment**

|  |  |
| --- | --- |
| Name:  [If address same as patient's enter 'SAME']  Home Address: | |
| Street  Contact Telephone: ( ) | Apt City State Zip  [Home] ( ) - [Day Time] |
| Employer: | Position: |
| Employer Address: |  |
| Surd  Employer Telephone: ( ) | Suilc Cily Stale Zip |
| Employer: | Position: |
| Employer Address: |  |
| Street  Employer Telephone: ( ) | Suilc Cily Slale Zip |
|  |  |

**Insurance**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Holder ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: ( ) Group/Policy No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorizations for Treatment, Payment, and Third-Part Billing**

I authorize Dr. Goldwater to provide

treatment to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient /Parent/ Legal Guardian Date

I confirm that I am responsible for payment for the services rendered

to me and my dependents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient /Parent/ Legal Guardian Date

I authorize Dr. Goldwater to bill a third party (My Insurance Company or the responsible party) and to give them such personal information they require to process the payment on my behalf.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient /Parent/ Legal Guardian Date