Robert Tuckman, LPC, EdS

4 Terry Drive
Newtown, PA 18938
609-731-9997

Client Registration Client Name:
_____ Today's Date: _____ Home Address: _____ City: _____ State: _____ Zip: _____ Email Address: _____
_____ Date of Birth: _____Gender_____ Home Phone: _____ Cell: _____ Client's Spouse/Partner (if applicable): _____ (If Client is a Student) Name of School: _____
Grade:_____ Family Physician: _____ Psychiatrist (If applicable): _____ Current medications & dosages: _____ Person to contact in an emergency: _____ Phone: _____ Would you like to receive text reminders for your appointments the day before? Y _____ N _____ On what number? _____

Financial Agreement I have agreed to pay privately for my general psychology services. The agreed upon charge is $_____ for each session. The initial intake session is 60 minutes. All subsequent sessions are 50 minutes long for adults, and 45 minutes for children and adolescents, unless another arrangement is made. Testing, paperwork and other requests will be a separate cost according to the current Fee Schedule. Payment is due at the time of service. I acknowledge that Robert Tuckman, LPC, EdS will not bill my insurance company, but will provide me with a receipt for service. Additionally, I acknowledge that my insurance company may not reimburse me for psychological Services provided by Robert Tuckman, LPC, EdS. There is a 24 hour cancellation policy which requires that you cancel or reschedule your appointment 24 hours in advance. Failed appointments (no cancellation) or same-day cancellations will be charged the full fee.

Signature: _____ Date: _____

For Treatment of a Minor As the parent or legal guardian of _____, I authorize his/her evaluation and treatment by Robert Tuckman, LPC, EdS As parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

Signature: _____ Date: _____