Marty I Glass, MEd.
Licensed Professional Counselor

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NEW PATIENT INFORMATION SHEET

CELL___ HOME___ OFFICE___
Phone_____

NAME_____

LAST FIRST MIDDLE

ADDRESS_____

CITY_____ STATE_____ ZIP_____

SEX____ DOB_____AGE____

MARITAL STATUS_____

EMPLOYER_____PHONE_____

ADDRESS_____CITY_____ST_____ZIP_____

STUDENT STATUS_____SCHOOL_____

EMERGENCY NAME, ADDRESS AND PHONE_____

_____

REFERRAL SOURCE_____FAMILY PHYSICIAN_____

PSYCHIATRIST_____

I understand that it is my responsibility to file any claim for insurance reimbursement of services rendered by Marty Glass LPC, should I decide to do so.

I understand that FULL PAYMENT of session fee is required for a MISSED APPOINTMENT with Marty Glass LPC if not canceled with AT LEAST 24 HOURS NOTICE.

SIGNED_____ DATE_____
PATIENT or RESPONSIBLE PARTY