REN MASSEY, PH.D. Licensed Psychologist Phone: 404-292-3400
1244 Clairmont Road, Suite 101 Decatur, GA 30030 Fax: 404-292-3444

CLIENT INFORMATION

NAME_____ BIRTHDATE_____

ADDRESS_____ SOC.SEC.#_____

_____ HOME PHONE_____

REFERRED BY_____ CELL PHONE_____
EDUCATION LEVEL_____ EMPLOYER OR SCHOOL_____
POSITION AND # OF YEARS_____
WORK OR SCHOOL ADDRESS_____ WORK PHONE_____
PERSON RESPONSIBLE FOR BILLS_____ RELATIONSHIP TO RESPONSIBLE PARTY_____
NAME OF INSURED_____ INSURED'S BIRTHDATE_____

INSURANCE_____ GROUP #_____
PHONE # OF INSURANCE CO._____ SUBSCRIBER #_____
HEALTH CONCERNS & MEDICATIONS_____
EMERGENCY CONTACT PERSON_____ RELATIONSHIP TO EMERGENCY CONTACT_____
PHONE #'s FOR EMERGENCY: HOME_____ WORK_____

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I hereby authorize Dr. Massey to provide psychological services to myself and/or the minor in my custody.

_____ _____ _____
NAME SIGNATURE DATE

I hereby authorize Dr. Massey to bill my insurance company for services provided.

_____ _____ _____
NAME SIGNATURE DATE

I agree that I, or the agency I represent, am responsible for bills not paid by the insurance company.

_____ _____ _____
NAME SIGNATURE DATE

I HAVE BEEN INFORMED THAT I AM RESPONSIBLE FOR FEES FOR SESSIONS NOT CANCELED 48 HOURS IN ADVANCE.

_____ _____ _____
NAME SIGNATURE DATE