

Adina McGarr, Psy.D
Clinical Psychologist, PSY 22253
818-518-6775
www.mysantabarbaratherapy.com

NEW CLIENT FORM

Today's Date _____ Referred by _____

Client's Name _____ Age _____ DOB _____

Parent or Guardian _____

Address _____

Home Phone _____ Cell _____ Email _____

Insurance Carrier: _____ Drivers Lic. # _____ Marital Status S M W D

Insured's ID #: _____ Insured's Employer: _____

Group # _____ Phone numbers on insurance card: _____

Deductible: _____ Co-pay _____ Pre-authorization: yes no

Claims Address: _____

If you are not the policy holder (i.e. a dependent) please fill out the following information:

Policy Holder Name: _____ and ID # _____

Group/ID#: _____

PAYMENT AND INSURANCE REIMBURSEMENT: Payment is due at the time of session for private pay clients. If you have insurance and I am part of your network, your co-pay is due at the time of session. If provider (Adina McGarr) is not in-network, clients are expected to pay for services at the time they are rendered unless other arrangements have been made.

CANCELLATIONS AND EMERGENCIES: Appointments are made in advance. If you are unable to keep your scheduled appointment, please notify Dr. McGarr 24 hours in advance to avoid being charged. The fee will be waived for emergency cancellations.

EMERGENCY CALLS: When Dr. McGarr cannot be reached for urgent calls, clients are directed to call 911 or go to the local hospital emergency room.

CONFIDENTIALITY: All information disclosed within session is confidential and may not be revealed to anyone without written permission, except where disclosure is indicated by law. Disclosure may be required in the following situations: when there is information regarding child abuse or neglect or elder abuse; if Dr. McGarr is mandated to do so by the Court; when a person is a danger to self, others, or is gravely disabled.

CONSENT FOR TREATMENT: I authorize and request Dr. McGarr to carry out psychological examinations, treatments, and/or diagnostic procedures which now or during the course of my care (or dependent child) as a client are advisable. I understand that the purpose of these procedures will be explained to me and are subject to my agreement. I have read and fully understand the above information contained in this form.

Signature of Patient: _____ Date _____

Signature of Parent/Guardian/Conservator: _____ Date _____

Dr. Adina McGarr, Psy.D: _____ Date _____