

Marlene M. Maheu, Ph.D.
Licensed Psychologist PSY #11921
106 Thorn Street, San Diego, CA 92103
858-277-2778

New Client Information

Last Name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Date of Birth: _____ Age: _____
Relationship Status: _____ Name of Partner: _____
Driver's License No.: _____ Social Security Number _____
Occupation: _____ Ethnicity: _____
Employer: _____ Work Phone: _____
Employer's Address: _____
Other family members living at home (name, date of birth, relationship):

In Emergency Contact: _____ Phone: _____
Name/address of Nearest Relative: _____ Phone: _____
Referral Source: _____
May Dr. Maheu identify herself when she leaves a message at your home? yes no Work? yes no
Previous Therapist: _____ Address: _____
City: _____ State: _____ Zip: _____ Date of last visit: _____
If you received previous therapy, was your experience positive? yes no
Please give brief details: _____

Financial and Cancellation Agreement

I agree that any outstanding balance of my bill will be paid in full with postdated checks at the end of my work with Dr. Maheu. I also understand that notices of cancellation must be given at least by 5:00 p.m. of the business day prior to the scheduled day of appointment. Otherwise, I will be charged my full fee (not just my co-pay) for the missed session. In the event that it is necessary to commence proceedings to collect money due and owing for services rendered, I agree to pay reasonable collection cost and fees incurred including but not limited to attorney's fees.

Signature: _____ Date: _____

Health Insurance Coverage

Primary Insurance Carrier: _____
Name of Insured: _____ Contact: _____
Insurance Company Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ ID. No.: _____ Group No.: _____
Regardless if you choose to use it, do you have a secondary insurance carrier? If yes, please complete the following:
Secondary Insurance Carrier: _____
Name of Insured: _____ Contact: _____
Insurance Company Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ ID. No.: _____ Group No.: _____
Is pre-authorization required by your insurance carrier for out-patient mental health? If so, have you made the necessary phone call? Yes _____ No _____ You will be responsible for any balance not covered by your insurance carrier.

Authorization to Release Information

I hereby give Dr. Maheu authorization to release/receive information to/from my insurance carrier. Information will be limited to facts relevant to reimbursement only. I also give Dr. Maheu permission to fax data to my insurance carrier.

Signature: _____ Date: _____