Dr. Katherine Restuccia
Licensed Psychologist

Patient Information Form

Name:_____Date of Birth_____

Occupation:_____

Address:_____

Contact Information and Authorization

Home Phone:_____ OK to leave a message? Y /N

Work Phone_____ OK to leave a message? Y / N

Cell Phone_____OK to leave a message? Y / N

Which number do you prefer I use? Cell / Home / Work

In case of an emergency, whom should I contact?

Name:_____Phone:_____

Relationship to you:_____

Were you referred to my practice by either a friend or medical / mental health professional? Y / N
If yes, by whom?

Are you currently taking any medication(s)? Y / N
If yes, please list medications below and prescribing physician as well as approximate time you have been using them.

Do you have any current medical conditions? Y / N
If yes, please list below along with approximate date of diagnosis (use back of paper if necessary).

Have you had any outpatient mental health treatment prior to this appointment? Y / N
If yes, please list the name(s) of the mental health professional and approximate dates of treatment (use back of paper if necessary).

Have you ever been hospitalized on an inpatient unit for mental health issues? Y / N
If yes, please briefly describe the reason for your hospitalization and approximate dates (use back of paper if necessary).

If you are using health insurance, information about your treatment, such as diagnosis and dates of service, will be supplied to your insurance company in order to obtain payment for services. I only supply the minimum amount of information necessary in order to receive payment.

Except in the rare case of unexpected emergencies, I require a minimum of 24 hours notice for cancelling or rescheduling of any appointment. If you do not provide adequate notice, unfortunately I will have to charge you for the entire cost of the session ($150). Please note that if you are using insurance, your insurance carrier cannot be billed for the missed session and you will be charged for the entire cost of the session and not just the co-payment or coinsurance.

If the foregoing is acceptable to you, please sign below.

Signature_____Date: _____