Kate Roberts, Ph.D.,
Kate Roberts and Associates
Psychology Services
205 Willow St, Willowdale Bldg A, Suite 3, S. Hamilton, MA 01982
266 Essex St, Salem, MA 01970
978-884-1213

Date_____

Client's Name: _____ DOB: _____

Age: _____

Address:

_____

City, State, Zip: _____ Phone:

_____

Work Phone: _____ Mobile: _____ Text: Y or N

Email: _____

Best way to contact you? _____

Grade: _____
School:_____

School Address:

_____

Referral Source:

_____

Party Responsible for Payment

Custodial Parent or Legal Guardian Name:

_____

Date of Birth of Insurance Carrier_____

Insurance company name _____

Insurance card number _____

Copay Amount_____

Annual Deductible_____

Has Annual Deductible been used?_____

Party Responsible for Payment Address:

_____

City, State, Zip: _____ Phone:

_____

Parent address if different from above name and address_____

Work Phone: _____ Mobile: _____

Primary Care Physician Name and Location_____

_____

It is our policy to notify the PCP when a patient has been seen for the first time. This may be required by your insurance company as well as a condition for reimbursement.

Please sign and date one of the following:

Yes you may notify my PCP

_____

No, you may not notify my PCP

_____

Signature: _____ Date: _____

Can I add you to my email list for updates on current issues and blogs?