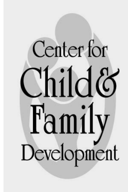

CENTER FOR CHILD & FAMILY DEVELOPMENT
145 WASHINGTON STREET
MORRISTOWN, NJ 07960

PATIENT INFORMATION		
NAME LAST	FIRST	M.I.
STREET		
CITY	STATE	ZIP
HOME PHONE	WORK PHONE	
CELL PHONE		
E-MAIL ADDRESS		
SOCIAL SECURITY #		
SEX	BIRTHDATE	
MARTIAL STATUS	STUDENT STATUS	
REFERRED BY		
MAY WE CONTACT THEM?		
EMERGENCY CONTACT	PHONE	
DOCTOR TO BE SEEN		
REASON FOR VISIT		

PARENT OR GUARDIAN INFORMATION			
PARENT/GUARDIAN	LAST	FIRST	M.I.
	SSN	BIRTHDATE	
PARENT/GUARDIAN	LAST	FIRST	M.I.
	SSN	BIRTHDATE	
ADDRESS (IF DIFFERENT)			
CITY	STATE	ZIP	
PARENT'S EMPLOYER		WORK PHONE	
RELATIONSHIP TO PATIENT (IF NOT PARENT)			

DIAGNOSIS CODES
DIAGNOSIS (TO BE SUPPLIED BY DOCTOR)

I hereby agree to pay the Center for Child & Development and/or Steven Tobias, Psy.D. for all charges related to treatment rendered to me or any of my family members at the time of service. I understand that I will receive a monthly receipt and that I am responsible for submitting all claims to my insurance company. If my insurance company requests it, I further authorize the Doctor to release any information concerning examination or treatment to the insurance company. Please provide a minimum 24 hour cancellation notice to avoid being charged for a missed appointment. In the case of your account going to collections, the collection fee will be passed on to your total collection amount. Please read the attached HIPAA Notice of Privacy Practices form and retain a copy for your records. By signing below, you acknowledge that you agree to the terms above and have received a copy of the Notice of Privacy Practices.

Patient/Parent Signature ___________________________________ Date _____________