Patient Form

Name: _____

Street address: _____

City, State, zip code: _____

Email address: _____

Date of birth: _____ **Cell phone:** _____

Emergency contact: _____

Relationship: _____ **Phone:** _____

Pharmacy: _____

Address: _____

Phone: _____

Medical conditions: _____

_____

Current medications, dose, frequency:

_____

_____

_____

Allergies: _____

Fee Contract: Dr. Schwartz does not accept insurance. You are responsible for payment in cash or check for each session at the time of the session. Nevertheless, you may decide to submit claims to your insurer for psychotherapy services rendered by an out-of-network psychiatrist. When you schedule a session with Dr. Schwartz, that hour is leased to you and to no one else. Cancelations of sessions must be made more than 24 hours in advance of the session, otherwise you will be held responsible for the fee. Failure to pay in a timely manner may result in termination of psychotherapy services.

Signature: _____ **Date:** _____