Joy Piccolino, PsyD
Licensed Psychologist

Client Registration

Date_____

1. Client Information

Client Name_____Date of Birth_____
Last Name First Name Initial

Address_____Home Phone_____

City_____State_____Zip_____ Cell Phone_____

Employer_____Occupation_____ Work Phone_____

Email address_____

2. Please indicate how you would like to pay for services by initialing one of the following:

_____ I give Joy Piccolino, PsyD, LP permission to bill my insurance company for services. I will be responsible for co-pays, deductibles, and fees that are not covered by my insurance.

_____ I will pay Joy Piccolino, PsyD, LP directly for services and give permission to bill my insurance company for possible out-of-network benefits that will be paid to me.

_____ I will pay Joy Piccolino, PsyD, LP directly for services and do not wish to involve insurance companies.

3. Primary Insurance

Primary Insurance Company_____

ID#_____Group #_____

Policy Holder Information (If the client is not the employee/policy holder):

Name_____Relationship_____
Last Name First Name Initial

Address_____City_____State_____Zip_____

Date of Birth _____ Employer_____

4. Secondary Insurance

Secondary Insurance Company_____

ID#_____Group #_____

Policy Holder Information (If the client is not the employee/policy holder):

Name_____Relationship_____
Last Name First Name Initial

Address_____City_____State_____Zip_____

Date of Birth _____ Employer_____