GREGORY G. LOMUTI, PH.D, ADC
Licensed Psychologist # 4150
8 Birchwood Court
Upper Saddle River, New Jersey 07458
Tel: 201-934- 9467 Fax: 201-934-5028

CONFIDENTIAL

INTAKE INFORMATION

Name_____ Date of Birth _____Today's Date_____

Please Check: Female _____ Male _____ Age _____ Social Security #:_____

Home Address _____City/State/Zip_____

Home Phone _____Work Phone _____

Employer/School & Address:_____

Occupation _____ Years of Education _____

Place of Birth _____ Religion, if applicable _____

Check One: Single _____; Married _____; Separated _____; Divorced _____; Widowed_____

Spouse's Name & Age_____

Spouse's Employer Address_____

Spouse's Occupation _____

Parents' Names & Occupations_____

Childrens' Names & Occupations_____

Sisters'/Brothers' Names & Ages_____

Emergency contact Name & Phone_____

Nature of Assistance you are seeking: (Please check)
Psychotherapy/Counseling _____ Psychological Testing _____ Neuropsychological Evaluation _____ Career Counseling _____ EMDR _____ Cognitive Rehabilitation _____ Hypnosis _____ Biofeedback ___Other _____

How did you hear about this service?

Describe the difficulties or symptoms for which you are seeking assistance.

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Describe any significant past or present medical or health related conditions, including injuries or accidents. Are you receiving treatment for any of these conditions? If so, explain:

Are you seeing or have you ever seen a psychologist, psychiatrist, counselor, social worker, psychotherapist, or received any type of personal or career counseling? If yes, when and what type of assistance have you received?

Have you ever been hospitalized for a medical or psychiatric problem? If yes, where and when?

Has anyone in your family ever received psychological/psychiatric assistance? If yes, please describe:

Have you or anyone in your family been identified as having had a learning difficulty? If yes, please describe:

Are you taking any medication? If yes, list name and dosage:

Do you use other non-prescription drugs or substances? If yes, please describe:

Do you drink alcohol? If yes, how often?

Do you smoke? If yes, how many cigarettes per day?

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On this Page Please Complete Two Signatures and Dates

A. I agree to accept responsibility for all payments of any services rendered to me by Health Psychology Associates/ Gregory G. Lomuti, Ph.D. and its providers. I understand that payment is expected at the time services are rendered unless prior arrangements have been made. I also understand that I will be charged for any appointments that I do not cancel 24 hours prior to my scheduled appointment. **For Patients with Traditional or Managed Health Care Plans, Medicare, Personal Injury, Workers Compensation, Victims Compensation, N.J. DVR**). I permit Health Psychology Associates/ Gregory G. Lomuti, Ph.D. to bill my Third Party Payor company for services provided.

_____ _____

Patient Signature **Date**

Acknowledgement of Receipt of HIPAA Notice

(See hand-out 'What you should know about HIPAA')

By your signature below, you indicate that you have received a copy of the "Notice of Therapists' Policies and Practices to Protect the Privacy of Your Health Information" from Health Psychology Associates/Gregory G. Lomuti, Ph.D.

B. _____ _____

Signature of Patient if 14 years or older **Date**

_____ _____

Print your name above **Birthdate**

_____

Signature of Parent/Guardian if pt. is under 18 years

_____

Signature of other Parent/Guardian if Joint Custody