

*Healing Hearts Therapy, LLC*  
*From the Office of Robin Newman, PsyD*  
*Licensed Clinical Psychologist*  
*Child and Adult Psychotherapy and Testing*



*Client Information*

Client's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Birthday \_\_\_\_\_ Spouse's Name (if married) \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact Name & Number \_\_\_\_\_

Primary reason seeking therapy today: \_\_\_\_\_

*I understand that I am responsible to pay for all services provided to me today.  
I also understand that I must give at least 24 hours notice in order to cancel an appointment or I will be billed in full for the missed appointment. In addition, I also understand that if I want Dr. Newman to bill my insurance company and they do not pay, I am liable for any and all charges not covered by my insurance.*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*