PAUL FOXMAN, PH.D.
Licensed Psychologist-Doctorate
86 Lake Street
Burlington, VT 05401
Tel (802) 865-3450 Fax (802) 860-5011

NAME:____________________________________ SOCIAL SECURITY #:_____________________________

DATE OF BIRTH:____________________ GENDER: M___ F___ EMAIL:______________________________

ADDRESS:_____________________________________ CITY:______________ STATE:______ ZIP:_______

OCCUPATION:_______________________________ EMPLOYED AT:________________________________

TELEPHONE: WORK____________________ HOME____________________ CELL____________________

PHYSICIAN NAME(S):____________________________ DATE OF LAST EXAM:______________________

EMERGENCY CONTACT:_____________________________________ PHONE #:_____________________

BILLING INFORMATION:

NAME OF PAYER (if other than self):_____________________________ RELATIONSHIP:_______________

ADDRESS:_____________________________________ CITY:______________ STATE:______ ZIP:_______

TELEPHONE: WORK____________________ HOME____________________ OTHER__________________

AGREEMENT (Please read and sign below):

I understand that regardless of my health insurance status, I am ultimately responsible for payment of fees.
I agree to pay for any missed appointments with less than 24 hours' advance notice.
I authorize the release of any information required to process my insurance claims.
I authorize health insurance payments directly to Dr. Foxman.

SIGNATURE:____ DATE:__________________

Office use: Dx____ Fee: ____________________________

Notes: ____