

Marsha Hewlett, Ph.D.
Clinical/Forensic Psychology

Patient Name: _____ Date _____

Address _____ HM Phone _____
Street _____

Employment _____
Name _____

Occupation _____ Education _____

Relationship Status:
Single/Never Married/Married/Separated/Divorced/Widowed/Significant Other
(Circle One)

Birthdate: _____ Age: _____

Number & Ages of Children or Others Living at Home with You _____

Medication(s) currently prescribed _____

M.D. _____
Name _____ Address _____

Previous Mental Health Treatment _____

Referral Source _____

Spouse/Significant Other Name _____

Address _____ HM Phone: _____

Date of Birth: _____ Education _____

Occupation _____

My usual and customary fee is \$180/hour.
Sessions are either payable upon receipt of services or billed monthly. The following is
my cancellation policy:

Hours scheduled are held for you exclusively, therefore:

- If seen once a week 48 hours notice is required or you will be charged at session rate
- If multiple sessions are scheduled weekly, two week notice is required or you will be charged at the session rate.

Your signature below acknowledges that the above policy information has been read
and agreed upon.

Signature _____ Date _____