**KATHRYN BERLÁ, Ed.D.**
Licensed Psychologist
2420 Frankfort Ave., Suite 200
Louisville, Kentucky 40206
502·412·2226

CLIENT INFORMATION

Name: ______________________________________DOB:_________________________

Address: ____________________________________________________ZIP_____________

Home Phone: _________________________ Cell Phone: ____________________________

Sex:______________Marital Status: ____________________ SS#:______________________

Employer:___________________________________Occupation:_______________________

Business Address:_________________________________________Phone: _______________

Whom may I thank for referring you?_______________________________________________

Emergency Contact Person: ______________________________________________________

Primary Care Physician__________________________________________________________

I hereby authorize payment directly to Kathryn Berlá, Ed.D. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above provider to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. With my signature I acknowledge the understanding that scheduled appointments must be cancelled with 48 hours prior notice in order to avoid the charge.

Signature of Responsible Party: ____________________________________Date: _______________