

**Dennis H. Karpowitz Ph.D.**

**Clinical Psychologist  
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Today's Date: \_\_\_\_\_

Name(s): \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Phone: \_\_\_\_\_ (Home) \_\_\_\_\_  
(Work)

\_\_\_\_\_ (Cell) E-Mail: \_\_\_\_\_

**Health insurance**

Name of Insurance Company: \_\_\_\_\_

Address to send bill: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Who should be billed for these services (if other than above)?

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City

State

Zip

Who lives in the same home or apartment with you?

Name	Age	Date of Birth	Sex (F/M)	Relation and at home or away

Psychology is not an exact science and no guarantees come with my clinical services. The cost for my clinical services is \$130.00 per fifty-minute session. Sessions requiring less time or more time are prorated. Those contributing 10% or more of their annual gross income to charity receive a \$10.00 fee reduction per session. **Payment is due at the time of service or within thirty days.** If payment is received at the time of service, an additional \$10.00 is deducted from the cost. If you have insurance, I am happy to help you with it by submitting the insurance claim. I have read the above statement and agree to comply with these requirements.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Why did you come to see me?

What would you like to accomplish?

Other