Amy R Indermuehle, PsyD
Licensed Psychologist

Date: _____

Name: _____ **Date of Birth:** _____

Address (Include city and zip code): _____

_____

Dr. Indermuehle may send mail to my home address ☐ Yes ☐ No

***Phone:** _____

Dr. Indermuehle may leave a message at this number ☐ Yes ☐ No

Dr. Indermuehle may send text messages to this number ☐ Yes ☐ No

***Email:** _____

Types of information that may be sent via email:

Information related to scheduling/appointments ☐ Yes ☐ No

Information related to billing and payments ☐ Yes ☐ No

Information related to your mental health treatment ☐ Yes ☐ No

Information related to Dr. Indermuehle's operations ☐ Yes ☐ No

Other Information: _____ ☐ Yes ☐ No

Insurance Information

Name of insured _____ Date of birth of insured _____

Employer _____

Emergency Contact Information

Name _____ Relation _____

Phone Number _____

*Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, Dr. Indermuehle cannot guarantee that those communications will remain confidential. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically. I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

_____ _____

Signature of Client/Parent/Legal Guardian Date