Laura Palmer, PhD, ABPP & Associates

Laura Palmer, Ph.D., A.B.P.P.
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PATIENT CONTACT INFORMATION

Please provide the following information for your records:

Name: Date of Birth:

Street Address:

City/Town: State: Zip:

Mailing Address (if different from above):

Home Phone: Work Phone: Cell Phone:

Preferred Email Address:

Person to contact in case of an emergency:

Home Phone: Work/Cell Phone:

Address:

Authorization for Use of Electronic Communication: I give Dr. Palmer permission to communicate with me through the following means when deemed beneficial to do so. Please check all that apply:

Home Phone: ☐ Work Phone ☐ Cell Phone ☐

Home voice mail ☐ Work voice mail ☐ Cellular phone voice mail ☐

Email: ☐

Reasonable steps will be taken to ensure the confidentiality of the above means of communication. However, messages could be inadvertently received or overheard by an unintended third party.

I have read the above authorization and agree to all aspects so specified.

_____ _____

Signature Date