



Michael Murrell, Psy.D.
Licensed Psychologist,
Missouri License PY 01874
Florida License PY 11777
Private Practice since 1987

Information Form

Patient Printed Name _____

Address _____ Zip _____

Email _____ Date of Birth _____

Social Security Number _____

Who referred you? _____ Married _____ Single _____

Emergency Contact _____ Phone _____

Your text _____ phone number _____.

You understand payment is due at the time of service and cannot be deferred. I further understand that 24 hours notice is required if there is to be a cancellation due to circumstances other than emergency health issues or a death in the family. Failure to provide adequate notice will result in a charge of \$100 and/or discontinuation of counseling services. Credit Card Expiration date is __/__/__. Your credit card number is _____.

Your SEC number on the back of your card _____. By signing below you are giving consent to participate in psychological counseling for yourself by Michael Murrell Psy. D. of Murrell Counseling Service LLC.

Also, by signing this this form, you acknowledge your intent to retain his services. Please download Spruce Medical Communication so that all of our communications are encrypted and HIPAA approved. If you choose to email or text outside of Spruce then you would be choosing to communicate in a manner that may put your personal information at risk.

Your signature also indicates that your agreement with the cancellation policy, the statement of your financial responsibility to pay the fee at the time of the session and your decision to use Spruce Medical Communication App as your means of texting and emails.

Signature _____ Date _____

Witness _____