***Irina Volynsky, Ph.D, Clinical Director  
NYS Lic. 68-017595 NJS Lic. 4732***

***440 West Street, Fort Lee, NJ 07024 (347) 879-0202***

**TODAY’S DATE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PATIENT INFORMATION SHEET

YOUR NAME\_ DOB

YOUR CHILD’S NAME (IF APPLICABLE) \_ DOB

CONTACT NUMBER \_ YOUR ADDRESS

YOUR EMAIL ADDRESS

EMERGENCY CONTACTS: NAME PHONE NUMBER\_

REASON(S) FOR TODAY'S VISIT

I agree for TEMA to keep my financial information/credit card # on file in a secure location and charge the session fee upon completion of each session.

YES NO

CREDIT CARD INFORMATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXPIRATION DATE\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV NUMBER\_\_\_\_\_\_\_

Please let TEMA know if you agree if a message is left for you regarding upcoming appointments or any other technical issues, if necessary, via text or email. Please be aware that TEMA cannot insure the privacy of this communication.

YES NO

I agree to use provided video-conferencing platform alone or combined with telephone calls for virtual sessions if health or safety related needs arise. Privacy laws apply to telemedicine and there will be no recording/sharing of the session content.

YES \_NO

Your signature below indicates that you have read the information in this document, including the Notice of Privacy Practices, and agree to abide by its terms during our professional relationship.

Print Name

Signature Date