4405 East West Highway, Suite 502
Bethesda, MD 20814
(240)479-4894

Patient Name: **Date:**

NEW PATIENT CONTACT FORM

PATIENT INFORMATION:

Last	**First**	**Middle**

Date of birth	**Age**

Address		

*Do I have your permission to send you mail for administrative purposes only that may include Protected Health Information such as your name or your receipts? **Yes** ☐ **No** ☐

Phone Number	**Alternative Contact Number**	**E-mail Address**

*Do I have your permission to leave you a message at this number for the purpose of scheduling only, that may include Protected Health Information (your name, our name and the reason for the call)? **Yes** ☐ **No** ☐

*Do I have your permission to email for the purpose of scheduling only, that may include Protected Health Information ? **Yes** ☐ **No** ☐

***Current medical or psychiatric concerns and/or diagnosis:**

***Current medications:**

***Current complaints and/or reason for seeking therapy:**

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Patient Name: **Date:**

1) LEGAL GUARDIAN (please disregard if patient over 18)

Last	**First**	**Middle**

Date of birth

Address

Do I have your authorized permission to send you mail for administrative purposes only that may include Protected Health Information such as your name or your receipts? **Yes** ☐ **No** ☐

Phone Number	**Alternative Contact Number**	**E-mail Address**

*Do I have your permission to leave you a message at this number for the purpose of scheduling only, that may include Protected Health Information (your name, our name and the reason for the call)? **Yes** ☐ **No** ☐

*Do I have your permission to email for the purpose of scheduling only, that may include Protected Health Information? **Yes** ☐ **No** ☐

2) LEGAL GUARDIAN (please disregard if patient is over 18)

Last	**First**	**Middle**

Date of birth

Address

Do I have your permission to send you mail for administrative purposes only that may include Protected Health Information such as your name or your receipts? **Yes** ☐ **No** ☐

Phone Number	**Alternative Contact Number**	**E-mail Address**

*Do I have your permission to leave you a message at this number for the purpose of scheduling only, that may include Protected Health Information (your name, our name and the reason for the call)? **Yes** ☐ **No** ☐

*Do I have your permission to email for the purpose of scheduling only, that may include Protected Health Information ? **Yes** ☐ **No** ☐

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Patient Name: **Date:**

EMERGENCY CONTACT INFORMATION

Emergency Contact Name	**Phone Number**	**Alternative Contact Number**

*This person would only be contacted in a life threatening emergency.

OTHER PROVIDERS:

Psychiatrist Contact	**Phone Number**	**Business Address**
Primary Care Doctor Contact	**Phone Number**	**Business Address**

EMPLOYMENT INFORMATION- please note that I will not contact your employer

Name of Employer	**Address**	**Phone**

BILLING:

Please complete the section below. I keep a credit card on file for all clients to ensure adherence to office late cancellation/ no show policy. If you do not show or for your appointment or late cancel for an appointment you will be charged for the session.

Name:	Security Code:
Card Number:	Exp. Date:
Billing Zip code	HSA card?

SUPERBILLS: *I can provide superbills for you to submit to your insurance company for possible reimbursement.*

I would like Superbills **Yes** □ **No** □

I would like Superbills emailed □

I would like paper Superbills given in person at the end of the month □

WHO REFERRED YOU HERE TODAY?

Name:	Saw Ad on Psychology Today? yes □ no □