



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

Client Name:

NEW CLIENT CONTACT FORM

CLIENT INFORMATION:

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Last

First

Middle

--	--	--

Date of birth

Age

--	--

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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**

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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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(240)479-4894
Date:

Client Name:

1) LEGAL GUARDIAN (please disregard if the client over 18)

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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**

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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 the client 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**

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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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Client Name:

Date:

EMERGENCY CONTACT INFORMATION

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Emergency Contact Name

Phone Number

Alternative Contact Number

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

OTHER PROVIDERS:

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Psychiatrist Contact

Phone Number

Business Address

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Primary Care Doctor Contact

Phone Number

Business Address

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

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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 the 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 Zipcode	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 <input type="checkbox"/> no <input type="checkbox"/>
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