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 Woodbridge, VA 22192
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Patient Registration Form

Briefly describe why you are seeking treatment:

Therapy Preferences:

Interest in Telehealth/ Online / Video Counseling? __Yes __No

Scheduling needs (preferred days/ times):

Demographic Information

Patient Name:	Social Security #(if adult):
Street Address:	Date of Birth:
City, State:	Zip Code:
Gender:	Marital Status:
Email Address:	Home Phone:
Restrictions When Calling?:	Work Phone:
Primary Care Physician:	Mobile Phone:
Emergency Contact Person:	Texting OK? Yes or No
Emergency Contact Phone:	Psychiatrist (if any):
	How did you hear about us?

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	Home Phone:
Street Address:	Work Phone:
City, State, Zip Code:	Mobile Phone:
Relationship to Patient:	Responsible Party SSN:

***Please be aware that in the case of divorced/separated parents, it is the responsibility of the scheduling parent to pay any patient balance due on a child's account. If there is a custodial financial agreement between parents, it will be the scheduling parent's responsibility to collect any money due.*

Insurance Information

Primary Insurance:	Policy Holder Name:
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:
Secondary Insurance:	Policy Holder Name:
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:

PATIENT AUTHORIZATION

I certify that all information provided is accurate. I authorize the provider to bill my insurance and receive reimbursement for services rendered. The provider is authorized to release necessary information to the billing staff and my insurance carrier to receive payment for services rendered. I understand that I am responsible for all charges not covered by my insurance. Furthermore, should legal action or collection services become necessary to collect my unpaid balance, I agree to pay all legal and/or

collection fees.

Signature: _____ **Date:** _____

By entering your name above, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this Agreement. You consent to the legally binding terms and conditions of this Agreement. You further agree that your signature on this document (hereafter referred to as your "E-Signature") is as valid as if you signed the document in writing. You also agree that no certification authority or other third-party verification is necessary to validate your E-Signature, and that the lack of such certification or third-party verification will not in any way affect the enforceability of your E-Signature or any resulting agreement. You are also confirming that you are the individual authorized to enter into this Agreement.