



NEW PATIENT REGISTRATION - INTENSIVE PROGRAM

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Cell () _____ Home Telephone () _____ Work() _____

Date of Birth _____ E-mail Address _____

MM DD YYYY

Marital Status: ___ Married ___ Single ___ Separated ___ Divorced ___ Widowed Other _____

Patient's Employer _____ Location _____

Occupation: _____ Type of Business: _____

How were you referred or who referred you _____

Name of primary therapist you are currently working with: _____

Information Pertaining to Spouse, Partner, or Significant Other

Spouse/Partner Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City _____ State _____ Zip _____

Cell () _____ Home Telephone () _____ Work _____

Date of Birth _____ Relationship to Patient: _____ E-Mail: _____

Spouse/Partner Occupation _____ Employer _____

Other Direct Family Members under age 18 to be involved - Names and Dates of Birth:

1. _____ 3. _____

2. _____ 4. _____

Responsible Party Name and Relationship to patient _____

Responsible Party Contact Phone Numbers _____

Please initial below:

a) Payment is due upon the provisions of the Intensive Program Agreement. Any services provided beyond the intensive program are due at the time of service or by prepayment. X _____ X _____
Patient Spouse,partner,significant other

b) Intensive programs are cash programs. This office does not participate with, accept or process insurance including Medicare. It is the responsibility of the client to notify your insurance carrier to obtain preauthorization for intensive services.

X _____ X _____
Patient Spouse,partner,significant other

c) I understand that if I cancel my intensive program that any payments made may not be refundable.

X _____ X _____
Patient Spouse,partner,significant other

I consent to consultation and/or treatment for the above mentioned person(s):

X _____ X _____

SIGNATURE OF PATIENT

TODAY'S DATE

SIGNATURE OF SPOUSE, PARTNER SIGNIFICANT OTHER

TODAY'S DATE

PRIVACY PRACTICES ACKNOWLEDGEMENT: I have been given the opportunity to read and review the Notice of Privacy Practices (Psychotherapist-Patient Services Agreement) either by hard copy or via the internet as part of my intensive program package.

X _____ X _____
Patient Spouse,partner,significant other