Personal Information Form

Patient Name: _____**DOB:** _____

Address: _____

_____

Phone: **(home)** _____ **Primary Care Physician:** _____

(cell) _____ _____

(work) _____ _____

SSN: _____ _____

Referred by: _____

For patients younger than 18 years of age, please complete the following:

Father: _____

Address: _____

_____

Phone: **(home)** _____

(cell) _____

(work) _____

Mother: _____

Address: _____

_____

_____

Phone: **(home)** _____

(cell) _____

(work) _____

Financial Agreement

I understand that payment is expected at the time of service. A fee of $25 will be assessed for any returned checks. I understand that I will be responsible for full payment if I do not give 24 hours notice of cancellation or change of appointment. I understand that my insurance company will not be responsible for this payment. I also understand that failure to maintain responsibility for payment may result in my account being sent to an independent agency for collection. I consent to the release of information for this purpose, and I agree to pay any costs associated with such collection. I authorize Frederick Psychology Center, LLC to release any medical or mental health information necessary to help me process insurance claims.

_____ _____

Patient/Parent/Guardian Date