HELLENIC THERAPY CENTER

567 Park Avenue, Suite 203 - Scotch Plains, NJ 07076 - (908) 322-0112

Registration

WELCOME!

Client Name:_____ Sex:_____ Marital Status:_____

Patient DOB:_____ Age:_____ Patient SSN:_____

Home Address:_____ Email address:_____

City:_____ State:_____ ZIP: _____

Home/Evening Phone:_____ Cell Phone:_____

Work Phone:_____ I prefer that you call me on my _____ phone

Call will be discreet, but please note any restrictions:_____

EMERGENCY CONTACT: Name:_____Phone:_____

Relationship to Client:_____

REFERRAL: Whom May I Thank:_____

Medical Doctor:_____ Phone:_____

Current Medications: Name, Dosage/Frequency, Prescribing Physician

_____

Patient Agreement:

1. All sessions are by appointment only. Payment due at time of service. (Cash, check, or major credit cards accepted.)
2. **CANCELLATION POLICY**: There is a 24-hour cancellation policy for all appointments. A cancellation fee will be charged for a full session in the event that it is missed.
3. The clinicians shall charge the Center's regular hourly fee for time spent on telephone consultations with schools, case-workers, child protection services, requested paperwork and other correspondence.

Signature (Client)_____ Date_____

Signature (Parent or Guardian)_____ Date_____

Chief Complaint as to why I came in today:

AUTHORIZATION TO RELEASE INFORMATION:
I authorize this office to release any information necessary to expedite my insurance claims including documentation required by my managed care case-workers should my plan require it.

Patient, Parent, Guardian Signature:_____ Date:_____