

REGISTRATION HISTORY

NAME: _____ TODAY'S DATE: _____
DATE OF BIRTH: _____ SEX: _____ SS#: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
HOME PH #: _____ CELL PH #: _____ E-MAIL: _____
PATIENT'S EMPLOYER (IF APPLICABLE): _____

If Applicable -

MOTHER: _____ **FATHER:** _____
MOTHER'S EMPLOYER: _____ **OCCUPATION:** _____
ADDRESS: _____
CITY/STATE/ZIP: _____
OCCUPATION: _____ **PHONE NO:** _____
FATHER'S EMPLOYER: _____ **OCCUPATION:** _____
ADDRESS: _____
CITY/STATE/ZIP: _____
OCCUPATION: _____ **PHONE NO:** _____

If Applicable -

SPOUSE'S NAME: _____
SPOUSE'S EMPLOYER: _____ **OCCUPATION:** _____
ADDRESS: _____
CITY/STATE/ZIP: _____

IF PATIENT IS A MINOR, NAME AND ADDRESS OF PARENT OR LEGAL GUARDIAN THAT WILL BE RESPONSIBLE FOR ACCOUNT: _____

*In order to protect your privacy, please indicate by placing an * by the phone number(s) you would like to have appointments confirmed. If you are comfortable being contacted at any of the above numbers, please initial. _____*

IN CASE OF EMERGENCY WHO SHOULD WE NOTIFY: NAME: _____
RELATIONSHIP: _____ PHONE: _____

NAME OF FAMILY PHYSICIAN: _____ PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Please Read The Following Carefully:

I UNDERSTAND THAT THE POLICY OF THIS OFFICE IS TO EXPECT PAYMENT ON OR BEFORE THE DATE OF SERVICE. I ALSO UNDERSTAND THAT EXCEPT BY PRIOR AGREEMENT, THE FILING OF ANY INSURANCE CLAIM IS THE RESPONSIBILITY OF THE PATIENT OR LEGAL GUARDIAN. I AGREE TO PAY FOR ANY SERVICES BILLED TO ME ONLINE UPON RECEIPT OF THE BILL. MY SIGNATURE BELOW ALSO SHOWS THAT IF COLLECTION PROCEDURES BECOME NECESSARY, THE COST WILL BE ADDED TO MY PATIENT BALANCE.

DATE: _____ SIGNATURE: _____

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT & HIPAA NOTICE FORM

Your signature below indicates that you have read the Psychotherapist-Patient Agreement booklet provided to you upon registration or on the DrFred.Net Website. Your signature also indicates that you agree to its terms and also serves as an acknowledgement that you have received the HIPAA Notice Form described above.

DATE

LEGAL SIGNATURE OF CLIENT
PARENT/GUARDIAN OR CLIENTS AGENT

DATE

WITNESS SIGNATURE

CANCELLATION POLICY

We are happy to schedule your appointments to meet your scheduling needs. As you know, office visits are scheduled on an individual basis. The time of your appointment is reserved exclusively for you. If you miss your appointment, we lose the opportunity to offer this time to someone else.

This policy applies to ALL appointments including telephone, internet, and office visits.

Therefore, if you need to cancel your appointment, we ask that you provide a minimum of 24 hours advance notice **on the business day prior to your appointment.** Please note that our business days are Monday through Thursday. We will attempt to reschedule your appointment for any other time available.

Please be advised that Fridays, evenings and weekends are not considered business days as our office is usually closed. Messages received on these days will not be received until noon the next business day.

If 24 hours advance notice on the prior business day is not given, you will be charged for the missed appointment time.

I understand the cancellation policy as described and agree to adhere by this policy.

DATE

LEGAL SIGNATURE OF CLIENT
PARENT/GUARDIAN OR CLIENTS AGENT

DATE

WITNESS SIGNATURE