

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.
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:** _____