Frederick Psychology Center
220 N. Market Street ⋄ Suite 302 ⋄ Frederick, Maryland 21701
301.695.6455 ⋄ www.frederickpsychologycenter.com

Personal Information Form

Patient Name: ____DOB: __________________

Address: ____

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Phone: (home) _____________________________ (cell) _____________________________

Email: ________________________How would you like to be contacted? ________________

If we do not reach you by phone, may we leave you a message? _____________

Primary Care Physician: ____

Referred by: ____

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

Father:____

Address:____

____

Phone: (home) _______________ (cell) __________________ (work) ____________________

Mother:____

Address:____

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Phone: (home) _______________ (cell) __________________ (work) _____________________

I understand that payment is expected at the time of service. A fee of $25 will be assessed for 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.

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Patient/Parent/Guardian Date