

THE BRANDYWINE CENTER, LLC

New Client Information

Date _____
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell _____
Email _____ OK to email? Yes _____ No _____
Date of Birth _____ Age _____ Relationship Status _____

Who referred you to our practice? _____

Do I have permission to send them a "Thank You for the referral" note? Yes _____ No _____

If someone other than you is responsible for payment:

Name _____ Relationship to you _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell _____

Please Read:

I understand that I am responsible for my bill. I also understand that 24 hours must be given prior to canceling an appointment or I will be responsible for payment in full.

I have received a copy of The Brandywine Center's Privacy Policy

Signature _____ Date _____

Office use only

Therapist: _____

DX one _____ DX Two _____ Fee: _____
Bill Insurance _____ Bill client only _____ Authorization # _____
#sessions authorized _____ Start date _____ End date _____