PHOENIX HEALTHCARE OF VIRGINIA, LLC
Sondra B. Harry, PsyD
904 Princess Anne St., Ste. 301 Fredericksburg, VA 22401
Phone: (540) 898-8812 E-mail: Phoenixhealthcare1@gmail.com

PATIENT INFORMATION SHEET

Date:_____ **Referral Source:**_____

Last Name:_____**First Name:**_____**Birth Date/Age:**_____

Mailing Address:_____

Email:_____

Home Phone: (_____)_____ **Work**(_____)_____ **Cell** (____)_____

OK to Call? YES NO YES NO YES NO

OK to leave message? YES NO YES NO YES NO

Social Security Number:_____

Marital Status: Single Married Separated Divorced
Other:_____

Employer:_____ Full-time Part-time

PRIMARY INSURANCE
Patient's Relationship to Insured:___Self_____Spouse_____Child_____Other
Insured's Name:_____
Insured's Birthdate:_____
ID Number:_____

Insurance Company Name:_____Tel. No.:_____
Policy/Group Number:_____
Policy Effective Date:_____

COVERAGE PROVIDED : Total fee amount charged is $120 per 45-50 min session

POLICY CONCERNING PAYMENT OF FEES

Our policy is that payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, payment is due at the time of treatment.

- I AGREE TO PROMPTLY PAY ALL CHARGES AT THE TIME OF SERVICE AND ACCEPT LEGAL RESPONSIBILITY FOR ANY AND ALL CHARGES FOR THE CLIENT NAMED ABOVE.
- **I AGREE TO PAY A CANCELLATION FEE OF FIFTY DOLLARS [$50] FOR MISSED APPOINTMENTS WITHOUT 24 HOUR ADVANCE CANCELLATION. MISSED APPOINTMENTS WITH NO PHONE CALL WILL BE CHARGED THE HOURLY RATE.**

SIGNATURE:_____DATE:_____

AUTHORIZATION

To enable Phoenix HealthCare of Virginia to file insurance claims on my behalf, I certify that the information provided is correct and I authorize the following:

- The release of any medical or necessary information to process insurance claims.
- Payment of medical benefits to Phoenix HealthCare of Virginia for care provided.
- A copy of this authorization may be used in place of the original.
- This authorization may be revoked at any time in writing.

Signature:_____Date:_____

Therapist's Signature:_____Date:_____