

**PHOENIX HEALTHCARE OF VIRGINIA, LLC**

**Sondra B. Harry, PsyD**

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**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: \_\_\_\_\_