Grace Counseling Center

1125 Heatherstone Drive, Suite 101, Fredericksburg, Va 22407
Phone (540) 548-4114 Fax (540) 548-2541

New Client Registration Form

Please Print and Fully Complete Both Sides of Form

Patient's Full Name: ____
First Middle Initial Last

Address: ____
Street City State Zip

Phone Contact: ____
Cell Phone Work Phone Email

Birth Date: ________________ Gender: ____ OR ____ Marital Status ____ OR ____
Male Female Married Single

Social Security Number: ____________________ Insurance Carrier: _____________________

Referred By: ____
How did you find Grace Counseling Center?

Last School Grade Completed: _____ Name of Current School or Employer: _____________________

Persons Living in Household

NAME:	AGE:

List Current Psychological Conditions:	List Current Psychological Medications:

Do you attend church? _____ Please Specify: ____
Name of Church Phone

Briefly state why you are seeking treatment: ____

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Signatures

Parent or Responsible Party

Full Name: ____(_____________)
First Middle Initial Last Relationship to Patient

For Insurance Purposes: ____
Name of Primary Insured: First Middle Initial Last

Phone Contact: ____
Cell Phone Work Phone Email

Birth Date: _____________________ Social Security #: ______________________

Employer: ____
Name of Company Phone

Insurance Carrier: __________________________ Phone Number: ____________________________

Member ID: ___________________________ Plan or Group ID: ___________________________

I have read the Informed Consent / Confidentiality Agreement / Cancellation Policy and agree to these conditions of treatment. By my signature below, I acknowledge my agreement to adhere to these conditions.

Client Signature: ____ Date: _________________

Parent or Guardian Signature: _______________________________ Date: _________________

HIPPA Notice

I have received the notice of HIPPA Privacy Practices for Grace Counseling Center and I have been provided the opportunity to review it.

Client Signature: ________________________________ Date: ________________________

Parent or Guardian Signature: _____________________________ Date: _________________

PAYMENT INFORMATION IN CASE OF CANCELLATION

Cardholder's Name: ____ Billing Zip: __________
First Last

Credit Card Number: _________-_________-_________-_________

Expiration Date: ______/______ Security Code (CSV): _______

Signature of Cardholder: ___________________________________