Thoughts & Emotions
MENTAL HEALTH THERAPY
7981 Eastern Avenue Suite C-5 Silver Spring MARYLAND 20910

Registration Form

Indicate Services: Referred By: _____

☐ Individual Psychotherapy

☐ Family Psychotherapy

Identifying Data:

Client Name:_____

Legal Gender: _____ Gender Identity: _____ Pronouns: _____ DOB: _____

Home Address: Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

_____ Other Phone: _____

Email Address:_____

Emergency Contact:_____ Phone Number: _____

Relationship to Client: _____

Do we have permission to: Call ___Y ___N Text ___ Y ___N Email ___Y ___N

Diagnosis:

_____

_____

Medications:

_____

_____

Reason for Referral:

_____

_____

Invoicing/Billing:

☐ Please check if you would like a monthly invoice (superbill) to submit for insurance reimbursement

Email Address if different than above for billing information to be sent (i.e. parent address):

_____