

Dr. David L. Kupfer, Ph.D.

7700 Leesburg Pike, #404
Falls Church, VA 22043
TEL/FAX: (703) 821-8990

Registration Form

Client's name: _____
First Middle Last

Home address: _____
Street

City State Zip

Date of Birth: _____ Age: _____ Sex: _____ Marital status: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Employer: _____

Work address: _____

E-mail address (optional): _____

Spouse: _____

Spouse's employer: _____

Spouse's work address: _____

Financially responsible person (if other than yourself): _____

Address Phone

Who referred you for services? _____

Primary Care Physician:

Address Phone

Previous mental health care: _____

Provider or facility's name: _____

Medications presently being taken, with dosages: _____

Current medical problems: _____

Health care plan name: _____

Address

ID#: _____ Group#: _____ Subscriber: _____

Client's SS#: _____

Other plans covering you: _____

Read and sign if using health care plan to help pay for these services:

I, _____, authorize David L. Kupfer, Ph.D. to apply for benefits on my behalf for services rendered. I request that payment be made directly to David L. Kupfer, Ph.D. I certify that the information provided regarding health care coverage is accurate. I authorize release of any necessary information to my health care plan to enable payment of claims. A copy of this authorization and assignment agreement can be used and considered valid. This will remain in effect until revoked by me in writing. I understand that I am legally responsible for all charges, whether or not paid by my health care plan. While Dr. Kupfer's office may file for payment from certain health care plans or help me understand the nature and limits of my coverage, I understand that I am still responsible for full payment of my fees and for understanding my coverage. If Dr. Kupfer's office does not file for payment from my health care plan, I understand that I can send in his Statement for Professional Services form (perhaps accompanied by a claim form) to my health care plan for them to reimburse me for payment I have made to his office. I understand that the content of our discussions will remain totally confidential unless I give written permission for the release of such information.

Signature

Date

For all clients to read and sign:

Payment is expected at the time of the session. If I wish to make other arrangements for payment, I am aware that I must talk to Dr. Kupfer about it in advance. Twenty-four hours notice is requested when I have to cancel an appointment. Dr. Kupfer reserves the right to bill me for the entire cost of the scheduled session for any scheduled session that I miss or cancel with less than 24 hours notice. I understand that my health care plan will not pay for these charges. I agree to assume responsibility for all charges incurred should collection of this balance become necessary, including court costs, 12% annual interest accrual, and attorney fees. I also understand that I will be charged \$25.00 for any checks returned by the bank. Since I have begun therapy to work towards an important goal, I agree that deciding to end therapy is a decision to be made through consultation with my therapist. When I feel like ending our therapy sessions, I agree to talk to my therapist about it in a scheduled session.

Client or responsible party

Date

Therapist

Date