Angela Rosillo Counseling Services
Delray Beach, Florida

NEW PATIENT INFORMATION

Last Name________________________First Name__________________________Initial_____
Address_______________________________City__________________State_____Zip_____
Home phone_______________Work___________________Mobile___________________
Emergency Contact____________________Phone______________Relationship____________
Date of Birth_________________Email Address_______________________________________
Marital Status_____Single_____Married_____Separated_____Divorced_____Widowed
Employer____City__________________________
Occupation_______________________________
How did you hear of us?____

Responsible Party:____
Relationship to Patient:____
Responsible Party Contact Phone Number____

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Please initial your acceptance of the following terms at the end of each statement:

1. Payment is due at time of session or when services are rendered X_____
2. We do not accept insurance, including Medicare, nor do we participate in any insurance plans. X___
3. If I file a claim on my own and the insurance carrier requests information directly from this provider, it is understood that the provider will not respond in any way until I have provided written permission to respond on my behalf. X___
4. One business day (24 hours) notice is required to cancel or change an appointment. I understand that if changes or cancellation is made within this 24-hour period, I will be charged the full therapy hour rate.

PRIVACY PRACTICES ACKNOWLEDGEMENT: I have received the Notice of Privacy Practices and have been provided an opportunity to read it. X___

I consent to consultation and/or treatment for the above-mentioned person:

______________________________________ ________________
Signature of Patient Today's Date

______________________________________ ________________
Signature of Responsible Party Today's Date