



Chesapeake ADHD Center
of Maryland
Specializing in Attention and Learning Disorders
8607 Cedar Street
Silver Spring, MD 20910

Client Information Sheet

*Please complete this form as soon as possible to secure your appointment.
The form can be E-mailed to officemanager@chesapeakeadd.com or Faxed to 301.562.8449
Call 301.562.8448 with any questions.*

Date of Initial Appointment _____

Name of Client: _____

Date of Birth: _____

Name of Parent: _____

SSN: _____

(If client is less than 18 years of age)

Permission to leave Voicemail at this number:

Home Phone: _____

Yes No

Work Phone: _____

Yes No

Cell Phone: _____

Yes No

I, _____, give the Center permission to communicate with me

(Client or parent if client is a minor)

via email at the following email address: _____, in order to set or

change appointments, or in response to phone calls or emails from me.

Signature: _____

Address: _____

City, State, ZIP: _____

Emergency Contact: _____

Cell Phone: _____

Relationship: _____

Work Phone: _____

Who referred you to this clinic? _____

Are you in treatment with a psychiatrist, psychologist, or psychotherapist? Yes No

If so, please give us their names(s): _____

Phone number(s): _____



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Payment information

Circle one: Visa MasterCard American Express Discover

Card Number: _____

Exp: ____/____ Billing ZIP code: _____

I _____ give permission to charge all appointments and other fees
(Cardholder's Name)
for _____ to the above credit card. I understand that I can find
(Client's Name)
fee information and policies at www.chesapeakeadd.com or at the Center. I also understand that I may
choose to instead pay by cash or check, but that this card will be kept on file for any outstanding charges.
I understand that if I choose to pay with a different card than the one listed above I must submit the
request in writing to the office, via the center's *Change of Payment Card* form, which is available at the
office and at www.chesapeakeadd.com.

Cardholder's Signature: _____ Date: _____

Person Responsible for Payment

Clients 18 years of age or older who would like anyone other than themselves, such as a parent paying for services, to have access to **financial information** at this center, please list their names and sign below.

Name(s): _____ Relationship to client: _____

Address: _____ City, State, ZIP: _____

Home phone: _____ Cell: _____ Work: _____

I give the Chesapeake ADHD Center permission to send encrypted invoices to the following email address _____. I am aware these emails are HIPPA compliant.

Client Signature: _____