

Client Information Sheet

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**Please FAX this form to 301.562.8449 as soon as possible in order to secure your appointment.
Call 301.562.8448 with any questions.**

Date of Initial Appointment _____

Name of Client: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City, State, ZIP: _____ Work Phone: _____

SSN: _____ Cell Phone: _____

E-mail Address: _____

_____ I prefer NOT to receive Chesapeake ADHD News and announcements about other Chesapeake services.

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): _____

By signing below, I certify that:

- I accept the Chesapeake Center policies, including my rights to patient records and rights to privacy under the Health Insurance Portability and Accountability Act (HIPAA).
- I understand that a copy of the Chesapeake Center policies is available to me upon my request, and that I can obtain a copy in the waiting room of the Center or at www.chesapeakeadd.com.

Name of Client (please print): _____

Name of Parent: _____
(if client is under 18 years of age)

Signature of Client: _____
(or Parent, if client is under 18 years of age)

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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
(Cardholder's Name)

fees for _____ to the above credit card. I understand that
(Client's Name)

I can find 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.

Cardholder's Signature: _____ Date: _____

Person Responsible for Payment (if someone other than the client):

I would prefer statements be sent to ___ me (client) or ___ personal responsible for payment.

Name: _____ Address: _____

Relationship to client: _____ City, State, ZIP: _____

Home phone: _____ Cell: _____ Work: _____

If the client is 18 years of age or older and would like anyone else, such as a parent who is paying for services, to have access to financial information at this center, please list their names and sign below.

Person(s) who can access information: _____

Signature: _____