The Bethesda Group Psychological Services, LLC
Old Georgetown Office Park • 7988 Old Georgetown Road, 8A • Bethesda, Maryland 20814
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Patient Registration Form

Name:_____Age:_____DOB:_____Sex:_____

Home Address:_____City:_____Zip:_____

Phone: H_____W_____C_____
Which number is best to reach you? ☐ Home ☐ Work ☐ Cell

May I use email to contact you? Email address: _____

Emergency Contact:_____Tel:_____Relationship_____

Name of Employer / School:_____City:_____State:_____
Job Title / Grade:_____ Job Duties:_____

Referral Source: How did you hear of this practice?

☐ Psychologist: _____
☐ Psychiatrist: _____
☐ Other Provider:_____
☐ Friend or Relative_____
☐ Other_____
☐ TheBethesdaGroup.com
☐ American Psychological Association
☐ Maryland Psychological Association
☐ Psychology Today Therapist Finder

Payment Policy

I understand that insurance coverage varies widely. It is my responsibility to know which outpatient psychology services are covered, and what my payment responsibility is.

I understand that I will be charged for missed appointments unless I provide 48 hours (2 days) advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control.]

I understand that I am legally responsible for all charges for services provided. Should my account be referred to a collection agency / attorney I will be responsible for any additional fees related to that service.

I authorize my provider to release information required by the insurance company to process claims for the payment of benefits.

Signed_____Date_____.
Signature of patient or authorized person