DONNA MORRISH, M.S. **510 290-0989**

21847 Redwood Rd. Castro Valley, CA 94546
Licensed Marriage, Family Therapist (CA) MFC23510
Registered Psychotherapist (CO) NLC.0104058

Patient Registration Record

Name _____ Date of Birth _____ Age _____

Address _____ City _____ Zip _____

Telephone # (home) _____ Work _____ Drivers License _____

E-Mail _____ Employed by _____

Address of Employment _____

Referring Physician Name _____ Phone # _____

If patient is a minor child, name of guardian(s) _____

Soc. Sec. # of guardian _____ School Name _____ Grade _____

Emergency Contact Name _____ Phone # _____

Insurance Company Name _____ Policy # _____ Group # _____

Address _____

_____

Agreement for Psychotherapy Consultation Services

A full fee will be charged for missed appointments not cancelled at least **24 hours** in advance. E-mail or a 24 hour voice mail is available to leave messages.

I understand that I am responsible for payment of services. Arrangements can be made to bill my insurance company directly. I am aware that it is my responsibility to verify coverage for Mental Health Services with my insurance company. I will pay my co-pay amount or that portion which my insurance will not cover at time of service. Furthermore, I am responsible for any balance, including deductibles not covered by insurance. Should my account become delinquent, I authorize Donna Morrish to release all information necessary to a designated agency to secure reimbursement for services rendered. Typically, this involves releasing name, address, phone numbers and account information and excludes information regarding your treatment.

I have signed the Disclosure Statement and I have read and understand the financial responsibility statement and cancellation policy. I agree to all conditions therein. I further agree, if applicable, to assign direct payment from my insurance carrier to Donna Morrish, M.S. M.F.T.

_____ _____

Signature Date