

CENTRA^{PC}

COMPREHENSIVE PSYCHOTHERAPY & CONSULTATION ASSOCIATES

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Thank you for choosing Centra Comprehensive Psychotherapy & Consultation Associates. We appreciate the confidence you have placed in us. Please fill out the following information and let us know immediately if you have any questions.

CLINICIAN: _____ DATE: _____

Patient Information

Address and telephone number where you are to receive confidential correspondence & phone calls:

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE (H) _____ (W) _____ (Cell) _____

PRIMARY PHYSICIAN: _____

Name

Address

EMPLOYER NAME & ADDRESS: _____

HOW DID YOU HEAR ABOUT CENTRA?

Referred by: _____

Name

Phone Number

Centrapc.com Internet Mailing

Advertisement: _____

Please describe

Responsible Party: Self Other: Name _____

Address: _____

PHONE (H) _____ (W) _____ (Cell) _____

➡ IN THE EVENT YOU NEED TO CANCEL AN APPOINTMENT, PLEASE GIVE 24-HOUR NOTICE.
FAILURE TO NOTIFY WILL RESULT IN A CHARGE FOR THE MISSED SESSION.