THE ANXIETY & AGORAPHOBIA TREATMENT CENTER
112 BALA AVENUE
BALA CYNWYD, PA 19004
610.667.6490; Fax 610.667.1744
www.aatcphila.com

Name_____ Date_____

Address _____ Age_____ Date of Birth_____

City, State _____ Zip _____

Phone: Home _____ OK to leave message? Y N

Work _____ OK to leave message? Y N

Cell _____ OK to leave message? Y N

Email Address _____ OK to use this? Y N

Occupation _____Education_____

Marital Status _____ Spouse's Name _____

Emergency Contact_____ Phone (_____) _____

Referral Source _____

Previous Therapy _____

Medications _____

Please note we are an out-of-network provider for insurance. We will assist you as much as possible with insurance reimbursement. However, please note that your insurance company makes all final decisions regarding eligibility when they process your claims. If you have any concerns about coverage, you should contact your insurance company directly.

Privacy of Health Information: I have received a Notice of the Psychologists' Policies and Practices to Protect the Privacy of my Health Information. I authorize the release of any Protected Health Information for the purpose of treatment, payment and health care operations. I understand that I will be required to sign an additional authorization before any more specific information is released.

In signing this document, I also give my permission and consent to the Anxiety and Agoraphobia Treatment Center to provide psychotherapeutic treatment to me.

I accept responsibility for payment in full for all services rendered at the Anxiety and Agoraphobia Treatment Center. I understand at least 24 hours notice is required to cancel or change an appointment or I will be charged for the time.

Signature _____Date _____

For Office Use: Initial Intake completed by _____

Therapist_____Availability_____

Diagnosis:_____