

Williamsburg Wellness Counseling Center

REGISTRATION INFORMATION

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1. Do we have your permission to call and / or leave phone messages at your

home phone # _____ ☐ Yes ☐ No

work phone # _____ ☐ Yes ☐ No

cell phone # _____ ☐ Yes ☐ No

If the answer to all of the above is "NO", then how may we contact you? _____

2. Please designate the address to which we have your permission to mail correspondence.

3. In case of an emergency, whom should we contact?

Name _____ Relationship _____

Phone # _____ ☐ home ☐ work ☐ cell

Phone # _____ ☐ home ☐ work ☐ cell

Who may we thank for referring you? _____

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RELEASE & ASSIGNMENT OF PAYMENT

My signature verifies that the information that I have given is correct to the best of my knowledge.

I understand that it will be held in strictest confidence, and that it is my responsibility to inform this office of any changes in a timely fashion.

I understand that I am financially responsible for all charges whether paid by my insurance carrier or not.

I hereby authorize Hope Dillard to release any information necessary to secure payment of benefits by my insurance company.

I authorize the use of this signature on all insurance claim submissions whether manual or electronic.

I agree to pay all copays, deductible amounts, etc. at the time of service as required by my insurance company.

I agree to abide by the cancellation policy of "a minimum of 24 hours prior to an appointment" and to be responsible for any late cancellation or no show fees incurred for not having adhered to the stated policy.

I agree to be responsible for any delinquent fees incurred in the collection of any monies due.

Signature _____ Date ____ / ____ / ____