Registration Form

CLIENT NAME: _____

RESPONSIBLE PARTY: (if under the age of 18))
_____

ADDRESS: _____

TEL (HOME): _____ TEL (Office): _____
TEL (CELL): _____
EMAIL: _____

Current AGE: _____ DATE OF Birth: _____

GENDER: male female

EMERGENCY NAME(S) & TELEPHONE NUMBERS: _____

_____

How did you hear about my practice? □ Physician □ Website □ Internet □ Non-physician referral □ Phone book □ Other _____

PAYMENT POLICIES & AUTHORIZATION: I authorize Samuel D. Smithyman, Ph.D., and/or his agents to collect fees for services rendered to me and/or any other persons for whom I am responsible. I agree to pay Dr. Smithyman in full at the time of service and/or within 30 days of any statements sent to me via email, unless a different written agreement has been established between us. I agree to provide no less than 24 hours' notice when canceling or changing my appointments, so that Dr. Smithyman can schedule an appointment with someone else during what would have been my scheduled session.

I understand that when I give less than 24 hours' notice for cancellations, I will be responsible for the full session fee. I understand that failure to show for any appointment not cancelled or rescheduled prior to its previously agreed upon scheduled time, will be charged to me at the regular session fee.

I acknowledge that I am aware that Dr. Smithyman is not an in-network provider with my insurance carrier and that if he will not submit insurance claims directly to my insurance carrier for me. If I choose to submit claims on my own behalf, Dr. Smithyman will provide me with a statement that I will send to my insurance carrier for reimbursement which they send directly to me and not to him.

I am aware that Dr. Smithyman accepts only Venmo, personal or cashiers checks or cash as payment for my sessions with him

SIGNATURE:

_____ DATE: _____