MARK C. PURCELL, PSYD
Licensed Psychologist

CLIENT REGISTRATION FORM

Billing Information: Client

Client Name:_____
Address:_____
_____
_____
Phone: _____
E-Mail: _____
Fee/Co-Pay Per Session: _____

Ins. Company:_____
Group #:_____
I.D. #:_____
D.O.B.:_____ Age:_____
Sex: M F ____
EAP: Y N ____

Person Responsible for Bill

Primary Insured: _____
Address (If different than above):
_____
_____
Phone No.: _____
E-Mail: _____

Ins. Company:_____
Group #: _____
I.D. #: _____
D.O.B. _____ Age: _____
Employer: _____
Employer Address:_____
_____

Payment is due at the time of each session, unless other arrangements have been made with the treating therapist.

I agree that I am responsible for full payment of my account. I understand that the balance of my account is due and payable prior to the release of any reports.

I agree to pay for any missed appointments if I fail to give 24-hour notice.

In signing this form, I authorize Mark Purcell, PsyD to collect from and provide oral and/or written information to my insurance, Worker's Compensation, Victim Witness, law firm, or any other party responsible for payment on my account.

_____ _____
Signature ***Date***

1139 San Carlos Ave., Suite 303
San Carlos, CA 94070
Ph: 650.421.6518 Fax: 650.472.3710

mark@drmarkpurcell.com
www.drmarkpurcell.com
PSY 23702