Virginia D. Reiber Ph.D. CGP
Psychologist

DEDHAM PSYCHOTHERAPY
601 High Street, Suite 204, Dedham, MA 02026 | (781) 352-0930

REGISTRATION FORM

Name: _____ **Date of Birth**: _____ **Sex**: __ M __ F **Marital Status**: _____

Address: _____ **City**_____ **State** ____ **Zip** _____

Patient Bills to: _____ **Email Address** _____

Home Phone: _____ Number that messages may be left at : _____
Client Soc. Sec # _____ Client Employer: _____
Emergency Contact Name: _____ Contact Phone:_____
Referred By: _____ Primary Care Physician
_____

Family Members/Others Living in Home

Name	Relationship to Client	Date of Birth	Occupation

INSURANCE INFORMATION

**Attach Copy of Insurance Card (front and back)

Primary:
Name/Type: _____ **Client ID #** _____
Subscriber Name _____ **Group/Plan #** _____
Subscriber's Employer: _____ **Authorization #** _____

Secondary:
Name/Type: _____ **Client ID #** _____
Subscriber Name _____ **Group/Plan #** _____
Subscriber's Employer: _____ **Authorization #** _____

I authorize the release of information that may be required by my health insurance company and is necessary for treatment plan updates and to submit claims and pursue claim payments. I understand that Virginia Reiber, Ph.D utilizes a billing person who may interact on their behalf with my insurance company. This billing person is also bound by state and federal rules of confidentiality. ***I understand that I am financially responsible for all charges regardless of my insurance coverage.***

_____ _____
Patient or Adult Guardian (if minor) Date

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Date of First Appointment: _____ DX: _____
ID Checked _____ Yes _____ Pt Refused