FREDERICKSBURG PSYCHOLOGICAL SERVICES
1119 Caroline Street Fredericksburg, VA 22401

540-371-2251
alexanderBory@gmail.com

Dr. Alexander Bory, Ph.D, ABPP Dr. Eric Swift, Ph.D. Dr. Megan Gramm, Ph.D.

Please answer the following questions in order to help us to address your concerns.

Briefly describe your reason for seeking help:_____

_____

_____

Who suggested that you contact this office?_____

Your Primary Care Physician is:_____

When were you last examined by a physician?_____

Have you ever received psychiatric or psychological help or counseling of any kind before:_____

If yes, please explain why:_____

Please CIRCLE or MARK any of the following problems that you are experiencing:

lack of Appetite	sexual problems	bladder control
excessive drinking	appetite disturbance	difficulty relaxing
anger management	stomach problems	fears/phobias
problem drug use	pain	obsessive thoughts
nervousness	low self-esteem	relationship problems
fatigue	compulsive behavior	panic attacks
anxiety	feelings of unreality	poor impulse control
loneliness	flashbacks	confusion
nightmares	concentration problems	difficulty trusting
intrusive thoughts	depression	marital/family problems
sleep disturbance	bowel problems	finances
headaches	self-control	health problems
legal matters	stress	memory
children	ideas of self-harm	don't know

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MEDICATION INFORMATION

Patient Name: _____ **Date:** _____

Please indicate any and all medications you are currently taking:

MEDICATION	DOSAGE	FREQUENCY	START DATE	DOCTOR

Fredericksburg Psychological Services, P.C.

New Patient Information

First Name _____ MI _____Last Name_____

Street Address _____

City_____ State_____ Zip_____

Email _____

Cell Phone _____ Can you/will you receive text messages? Y N

Secondary Phone _____Work? Home?

Gender: M F Birthdate: mm/dd/yyyy _____

Social Security Number _____

Responsible Party, if other than patient

Name_____ Relationship to patient_____

Address, if different from patient _____

Insurance Information: Please provide insurance card(s)

Condition related to: Employment? Y N Auto Accident? Y N Other Accident? Y N

Employer's Health Plan? Y N

Primary Insurance Company_____

Policy Holder _____Phone Number_____

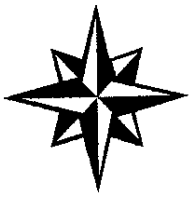
Patient relationship to insured: _____

Secondary Insurance Company_____

Policy Holder _____

Patient relationship to insured_____I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF BENEFITS DIRECTLY TO THE PROVIDER.

SIGNATURE _____ DATE _____



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OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Name:_____ID/SSN_____

Signature:_____Date:_____

It is my responsibility to pay any deductible amount, co-pay, co-insurance amount, or any other balance not paid by my insurance company.

I will pay a $25.00 service charge on all returned checks.

POLICY: There is a 24-hour cancellation policy, which requires that you cancel your appointment 24 hours in advance.
POLICY: You will be billed for missed appointments at the rate of $150.00. Insurance companies do not compensate for missed appointments.

Signature:_____Date:_____