Christine Komiske Dwyer, LCSW, LLC
4581 Lifestyle Lane
Midlothian, VA 23112

Today's Date:_____ Referred By:_____

Client's Given Name (First, MI, Last):_____

Client would like to be called:_____

DOB:_____ Age:_____ Gender:_____

Address:_____ City: _____ Zip:_____

Phone (please indicate type):_____

Email:_____

If applicable, Guardian(s) Name(s):_____Best Contact #:_____

Insured's name:_____ Insured's Date of birth: _____

Insured's employer:_____ Relationship to subscriber:_____

*This section may be left blank if a photo copy of the insurance card is made:

Primary Insurance Company:_____

Address of Insurance Company: _____

Policy Number:_____ Group Number:_____

Some insurance companies require a notification be sent to your primary care doctor. May we provide your primary care physician a notice that you are receiving mental health services? YES ☐ No ☐

Name of primary care physician: _____

I authorize the treatment of psychotherapy to myself or my dependent. If it should become necessary to pursue payment of this account by legal means, I understand that I may be charged legal/collection fees and up to 33 1/3 percent of the outstanding balance. I also understand that **there will be a $50 fee for appointments canceled with less than 24 hours notice.**

_____ _____
Signature and relation (self/parent/guardian) Date

_____ _____
Signature of additional client (including minor age 13 or older) Date

Phone: 804-608-9430 Fax: 804-510-0555
christinedwyerlcsw.com