Outpatient Registration Information

•14900 Bogle Drive, Suite 200 • Chantilly, VA 20151-1652 • 703-817-9890 • FAX 703-817-9860 • www.fcsva.org•

Basic Information

Full Name: ____ Date ____________________

Address: ____
Street City State Zip

County of residence: __________ Male ☐ Female ☐ Client's DOB: ___________ Age:___________

Ethnicity: __________________

Please list all contact numbers and indicate if it's OK (Yes/No) to leave voice mail at any of the numbers.

Home: ________________________ ☐ Yes / ☐No Work: __________________ ☐ Yes / ☐No

Cell: __________________________ ☐ Yes / ☐No Email: ____________________________________

Emergency Contact: ____
Name Number

How did you hear about us? ____

Briefly state presenting problem (be as specific as you can; when did it start, how it affects you): ____________
____
____
____

Estimate the severity of above problem (circle): ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Insurance Information

Primary Ins.: ________________________ Policy Holder Name: ______________________________

Policy #: __________________________________ Group/Member ID #: ____________________________

Policy Holder - DOB: ____________ - SSN: _______________________ Relationship to client: ___________

Policy Holder Employer: _________________________________ Occupation: ________________________

Insurance Co. Phone #: ____________________________ Authorization #: ___________________________

Secondary Ins.: ___________________________ Policy Holder Name: ______________________________

Policy #: __________________________________ Group/Member ID #: ____________________________

Policy Holder - DOB: ____________ - SSN: _______________________ Relationship to client: ___________

Policy Holder Employer: _________________________________ Occupation: ________________________

Insurance Co. Phone #: ____________________________ Authorization #: ___________________________

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Medical Information

Physician's Name: ______________________ Phone #: ______________________

Date of last exam: ______________________

Past/Present Medical Care (Specify major problems, accidents, hospitalizations): ______________________

____

____

____

Psychiatrist's Name: ______________________ Phone #: ______________________

Date of last exam: ______________________

Current Medications (specify what for): ______________________

____

____

Past/Present Counseling/Psychotherapy/Mental Hospitalizations: ______________________

____

____

Past/Present Drug/Alcohol Use/Abuse (AA/NA, Treatment): ______________________

____

____

I, ______________________ authorize the above named provider to apply for benefits on my behalf for covered services rendered. I understand that services must be paid for at the time of my appointment. I certify that the information is true and correct and further authorize the release of any information for this or any related claim, to the above named provider. I permit a copy of this authorization to be used in place of the original. Either the above named provider or I may revoke this authorization at any time in writing.

______________________ ______________________

Signature of Beneficiary or Subscriber Date

Office Use Only

FCS Therapist: ______________________ FCS Office: ______________________

Privacy Policy signed and on file: ☐ Yes ☐ No Date Signed: ______________________

Date of First Appointment: ______________________