Register As a New Patient

Name *

First Name Last Name

Patient Date of Birth *

Email *

example@example.com

Patient or Guardian's Cell Phone *

Area Code Phone Number

Patient's Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Request A Therapist

- ○ Karen Butler-Cook
- ○ Ron Czub
- ○ Amanda Cichanowski
- ○ Ashley Fazekas
- ○ Kristina Labriola
- ○ Max Cook

Type of Services sought *

- ○ Individual Therapy
- ○ Marital Therapy
- ○ Family Therapy
- ○ Sports Performance Consulting and sports mental acuity
- ○ _____

If you have selected "Marital Therapy", please provide the name of your partner?

If you have selected "Family Therapy", please provide the names of your family members?

Chief Complaint (insurance carriers ask for this information; choose most significant if more than one apply) *

- ○ Depression
- ○ Anxiety
- ○ Attention problems
- ○ Academic problems
- ○ Work-related problems
- ○ Childhood behavioral problems
- ○ Legal problems
- ○ Social or relationship problems
- ○ Cognitive or developmental delays
- ○ Autism Spectrum Disorder (Asperger's)
- ○ Health-related problems/chronic pain
- ○ Eating disorder
- ○ _____

Who Referred you to us?

Marital Status *

Employment Status *

Emergency Contact Name and Phone Number *

Name of Insurance Company *

Policyholder Name *

Policyholder Address *

Policyholder Date of Birth *

Group ID Number *

Name of person responsible for medical bills (if different than patient)

Claim Address (back of card) *

Customer Service phone number (back of card) *

Parent with custody (if patient is a child)

Member ID Number *

I have read and agreed to OFFICE POLICY, CONSENT TO TREATMENT, AND PAYMENT OF SERVICES on the following page *

- ○ Yes

Submit this form by filling it out completely and sending it to therapycenter1@msn.com