Beth Spring Therapy

1043 Sterling Road - Suites 203-204
Herndon, VA 20170
703-975-2628

Client Registration

Name			Email
Street Address			City/State/Zip
Occupation	Employer		Work Phone
Home Phone	Cell Phone		Using insurance for counseling?
Relationship Status S M D W Other	Date of Birth	Age	Referred by
Spouse/Parent Name			Spouse/Parent Phone
Spouse/Parent Address			

Please answer the following questions that may be relevant to therapy:

1. Do you have any medical conditions being treated by a physician? ☐ yes ☐ no
   If yes, please note condition and dates of treatment.

2. Are you currently taking medication? ☐ yes ☐ no
   If yes, please specify type and dosage.

3. Have you previously attended therapy sessions? ☐ yes ☐ no

4. Do you have any history of suicidal ideation or suicide attempt? ☐ yes ☐ no
   If yes, please explain.

Policy Concerning Payment of Medical Bills

Payment is due in full at the time services are rendered, unless other arrangements are made in advance. You will receive an invoice to submit for full or partial insurance reimbursement, if this is included in your benefits plan. It is your responsibility to arrange for reimbursement with your insurer.

I agree to promptly pay all charges when billed for services rendered, and I accept legal responsibility for any and all charges for the client named above.

Date:_____ Signature:_____