



72 Orchard Drive, Belleville, ON K8P 2K7  
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## Patient Registration

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 yy/mm/dd

(PLEASE PRINT)

Full Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

Person to Contact in Emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Email:** \_\_\_\_\_

### PARENTS (if under 18)

Name of Parents: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

If Student: ES: \_\_\_\_\_ HS: \_\_\_\_\_ College: \_\_\_\_\_

### Are you currently involved with: (check)

Children's Aid Society  Mental Health Clinic  Court

Children's Mental Health  Probation  Crisis

### OFFICE BILLING

1. I understand that I am responsible for the full amount of my bill for services provided.
2. Payment is due after each session, preferably by cheque.
3. Post-dated cheques are acceptable but only within a 2 week time frame.
4. Approval is required prior to the initial visit for special payment arrangements.
5. Fee Schedule:

Assessment, Consultation, Therapy

\$130/hr



Name: \_\_\_\_\_ (Please Print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### I UNDERSTAND AND AGREE TO THE FOLLOWING:

- A. There will be a \$25 service charge on all returned NSF cheques.
- B. In the event that my account goes to collections, there will be a 20% collection fee added to my balance.
- C. Interest charges of 1.5% per month will be applied to any invoice unpaid over 30 days.
- D. There is a 24-hour cancellation policy that requires me to cancel my appointment 24 hours in advance between the hours of 8:30 a.m. and 5:00 p.m. Monday through Friday to avoid being charged. (up to \$50)



Signature: \_\_\_\_\_ Date: \_\_\_\_\_