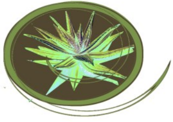

RITA PRELLER LCSW-C PSYCHOTHERAPY, INC.

1615 York Road
Suite 209
Lutherville, MD 21093

INTAKE FORM

Date of First Session: ____________________________

Patient's Name: ____

Who Referred You to Us? ____

Patient's Social Security Number: ____________________________________

Date of Birth: ____

Address: ____

Home Phone # and Cell Phone #: ____

E-Mail: ____

Name of Party Responsible for Payment: _____________________________________

Primary Care Physician Name and Phone #: ____

Primary Care Physician Address: ____

Psychiatrist Name and Phone # __________________________________

Permission to send records to Primary Care Physician (Yes) or (No) AND Psychiatrist (Yes) or (No)

School (if applicable) ____________________________________ (Grade) ______________

I agree to psychotherapeutic treatment for _____________________________________ (patient name).
I understand that there can be no guarantee of treatment success. I am aware that I will be responsible for late cancellations within 48 hours of scheduled appointment. However, there will be no charge for late cancellations in severe weather conditions. I understand that I am responsible for my account and must pay for services at time of rendering. If, in the event that my account is turned over to collections, I will responsible for all collections costs, interest, attorneys' fees and court costs.

Signature of patient or legal guardian: ____

Relationship to Patient:____

Date signed:____________________________________

Office phone # 410-323-1984 Fax # 443-519-5137 Email address rita@ritapreller.com