BiofeedbackWORKS in Virginia PLLC

CLIENT INFORMATION

Thank you for choosing Biofeedback*WORKS* in Virginia. Please **print** when completing the following:

Client Name: ___________________________________ Date of Birth: ____________________

Address *(residence):* ____

City ____________________________State ________________ Zip Code _____________

Home Phone: __________________________ Cell Phone: _______________________________

Work Phone: __________________________ Social Security Number: _____________________

Email: ____

Name of Spouse or Guardian: ____

Home Phone: ___________________________ Cell Phone: _________________________

Primary Care Physician: __________________________ Telephone: ________________________

Emergency Contact: _________________________________ Relationship: __________________

Home Phone: _________________ Cell: __________________ Work: _____________________

How did you hear about biofeedback?____

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How did you hear about Biofeedback*WORKS*? ____

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If you plan to file for insurance coverage of treatment:

- Please be aware that Biofeedback*WORKS* **does not** perform this filing.
- **Payment is due at the end of your office visit**. We provide a receipt for services that you can use when you file a claim with your insurance company.
- Please sign the following:

I authorize Biofeedback*WORKS* in Virginia to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Signature: ____ Date: ___________________________