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?_____

_____

How did you hear about Biofeedback*WORKS*? _____

_____

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: _____