CATHERINE L. MCCARTHY, M.D., PLLC
CHILD, ADOLESCENT AND ADULT PSYCHIATRY
6723 Whittier Ave., Suite 403
McLean, Virginia 22101
Phone 703-288-3535 · Fax 703-288-4334

Confidential Patient Information

Today's Date: _____ Gender: _____

Patient's Name: _____ Birth Date: _____

Home Address: _____ Home Phone: (___)_____

City/State/Zip: _____ Patient Cell: (___)_____

For Child and Adolescent Patients

School/College: _____ Parents' Marital Status: S M D W

Parent 1 Name: _____ Home Phone: (___)_____
(First, m.i., Last)

Work Phone: (___)_____

Parent 1 address if different from patient

_____ Cell Phone: (___)_____

_____

Parent 2 Name: _____ Home Phone: (___)_____
(First, m.i., Last)

Work Phone: (___)_____

Parent 2 address if different from patient

_____ Cell Phone: (___)_____

_____

For Adult Patients

Employer's Name: _____ Work Phone: (___)_____

Marital Status: S M D W

Spouse's Name: _____ Work Phone: (___)_____
(First, m.i., Last)

Cell Phone: (___)_____

Referred by: _____

Over →

PATIENT REGISTRATION POLICY

- I understand that the initial meeting is for the purpose of evaluation and to determine if a working relationship with Dr. McCarthy can be established.

- I understand that Dr. McCarthy is in solo private practice and does not share clinical responsibilities with other clinicians in the office suite.

- I agree to pay in full on my first visit and each visit thereafter. Dr. McCarthy does not participate with any insurance companies. Please note that **a monthly billing fee of $15 will be charged for all unpaid balances** that require billing by mail. Prescriptions and continued treatment will not be provided for patients with unpaid bills.

- An encounter form is provided at each visit, and can be submitted to an insurance company for possible reimbursement. I understand that some procedures, such as, but not limited to, missed or late appointments, preparation of reports, and extended telephone discussions, may not be covered by any insurance company and are my responsibility.

- Telephone calls will be billed as indicated in the current fee schedule.

- I clearly understand and agree that I am charged directly and I am personally responsible for payment of all services rendered to me (or the minor for whom I am responsible) in Dr. McCarthy's office.

- I agree that if I default on payment, I will pay collection costs, attorney's fees, and any an all court costs resulting from collection actions.

- I agree that if I am unable to give at least 24 hours notice of cancellation prior to an appointment, a charge for the time will be incurred.

- There will be a $15.00 charge for each prescription that is not either written or arranged to be mailed during a scheduled session.

I have read the Patient Registration Policy
My signature below indicates that I both understand and agree to this Policy

_____ _____

Signature of Patient, Responsible Party, Parent or Legal Guardian

Date