Colette de Marneffe, Ph.D.
8720 Georgia Avenue, Suite 205
Silver Spring, MD 20910
301-891-2120

Patient Information Form

Date of Initial Appointment: _____
Name of Patient: _____ Date of Birth: _____
Names of Parents: _____
(If patient is less than 18 years of age)

Permission to leave voicemail at this number

Home Phone: _____ ___Yes ___No

Work Phone: _____ ___Yes ___No

Cell Phone: _____ ___Yes ___No

I, _____, give Colette de Marneffe, Ph.D. permission to communicate with me via email for the purpose of setting or changing appointments, or in response to emails from me.

Signature: _____ Date:_____

Email address: _____

Mailing address: _____

City, State, Zip Code: _____

Emergency Contact: _____Cell Phone: _____

Relationship: _____Home Phone: _____

Work Phone: _____

Who referred you to Dr. de Marneffe? _____

Are you in treatment with a psychiatrist, psychologist, or psychotherapist? Yes___ No___

If so, please provide names
_____
_____

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Payment Information Form

I plan to pay for services with:

Check Visa MasterCard American Express Discover

Credit Card Number: _____

Exp: _____/_____ CVC#: _____ Billing zip code: _____

I, _____, give permission to charge all appointments and fees for (patient) _____ to the above credit card. I acknowledge that I have been provided with information about fees and policies from Colette de Marneffe, Ph.D. I understand that I may choose to pay by check or cash, but that this card will be kept on file for any outstanding charges.

Cardholder's signature: _____ Date: _____

If you are 18 years of age or older and would like anyone other than yourself, such as a parent, to pay for services and to have access to financial information related to treatment, please list name and sign below:

Name: _____ Relationship to Patient: _____

Address: _____

City, State, Zip Code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

I give Dr. Colette de Marneffe, Ph.D. permission to send invoices to the following email address: _____.

Patient Signature: _____ Date: _____