CHARLOTTESVILLE PSYCHOLOGICAL SERVICES, LLC
KRISTA JANA, PH.D.
700 HARRIS STREET, SUITE 201
CHARLOTTESVILLE, VIRGINIA 22903
(434) 227-6631

REGISTRATION FORM

PERSONAL INFORMATION

Client's Last Name, First, Middle _____ Date of Birth _____

Gender _____ Ethnic/ Cultural Identity _____

Street Address _____ City _____ State _____ Zip _____

Cell Phone | OK to leave message/ text? _____ Email | OK to email? _____

Employer's Name _____ Occupation _____

If client is a minor:

Legal Guardian _____ Relationship to Client _____

EMERGENCY CONTACT

Name _____ Relationship to Client _____

Cell Phone _____ Alternate Phone _____

REFERRAL INFORMATION

Name of Person Referring You _____ Yes No May I thank this person?

FAMILY PHYSICIAN

_____	_____
Name	Phone
_____	_____
Street Address	City State Zip

FINANCIAL INFORMATION

_____	_____
Name of Person Responsible for Account	Relationship to Client
_____	_____
Street Address	City State Zip
_____	
Phone	

I hereby give permission for Dr. Jana to email my invoices to me (if I have requested them), with the understanding that they contain personal information such as my name, dates of our meetings, and procedure and diagnostic codes. I acknowledge that email is not a secure means of transmission.

_____ (initial if you agree to receive emailed invoices)

_____
Email address to which invoices should be sent