Karen R. Stefano Ed.M, M.A., L.P.C. NCC
440 Robinson Drive
Winchester,Virginia 22602
WV License #1319
VA License # 0701007541

CLIENT REGISTRATION FORM

Today's Date:_____

Patient's full name:_____ SS# _____
Home
Address:_____City:_____
State:_____ Zip: _____
Home Phone:_____
Cellphone:_____
Marital status_____
Date of Birth _____/____/_____
Patient Employer:_____
Work Phone:_____
If Student:
High School or College:_____
Family Physician:_____
Referred By:_____
Person to Contact in Emergency:_____
Phone:_____

Insured/Responsible Party Information
Full Name of Insured:_____
Relationship:_____
Home Address:_____
Phone:_____
Insured SS#:_____
Insured's Primary Ins. Co.:_____
IDNo.:_____
Group No:_____

Billing and Insurance Policy

I understand that I am responsible for the full amount of my bill for services provided. There is a 24hour cancellation policy, which requires that you cancel your appointment 24 hours in advance between the hours of 8am to 4pm Monday through Friday to avoid being charged.
Name:_____

Signature:_____ Date:_____