

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

Patient Information Sheet

This form can be emailed to drcdemarneffe@gmail.com

Date of Initial Appointment: _____
Name of Patient: _____ Date of Birth: _____
Name of Parent _____ SSN: _____
(If client 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 at the following email address in order to
set or change appointments, or in response to phone calls or emails from me.

Signature: _____
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 and phone numbers:

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Payment Information

I plan to pay for services with: ___ credit card ___ check ___ cash

Circle one: Visa MasterCard American Express

Card Number: _____

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

I, _____, give permission to charge all appointments
(Cardholders name)
and fees for _____ 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: _____

Person Responsible for payment

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

Name _____ Relationship to client _____

Address: _____

City, State, Zip Code _____

Home Phone: _____ Cell phone: _____ Work: _____

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

Patient Signature: _____