

THE SOLUTION CENTER, LLC



100 Manetto Hill Road, Suite 205

Plainview, NY 11803

740 Veterans Memorial Highway, Suite 308

Hauppauge, NY 11788

516-650-6478

PATIENT INTAKE FORM

NAME: _____

Address: _____

Home #: _____ **Cell #:** _____

Employer: _____

School (if applicable): _____ **Grade (if applicable):** _____

NAME: _____

Address: _____

Home #: _____ **Cell #:** _____

Employer: _____

School (if applicable): _____ **Grade (if applicable):** _____

METHOD OF REFERRAL:

Web: _____ **Acquaintance:** _____

Physician: _____ *Other:* _____

**** PLEASE NOTE THE FOLLOWING POLICIES:**

All sessions are scheduled for 45 minutes, and for 40 minutes for children under ten.

All cancellations require 24 hours' notice. Clients are responsible for the full session fee for all missed appointments without the prior 24 hour notification, unless the session **can be rescheduled within the same week.**

Please feel free to discuss any questions regarding these policies with your therapist.

Thank you.