

Jennifer S. Battaglino, LCSW

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Date _____

NAME _____ DOB _____

Parent/Guardian(if applicable) _____

Address _____

City/State _____ Zip Code _____

Phone _____ Cell/Work _____

Which number would you prefer I use to call you? Home Cell Work

Email _____

Will you accept correspondence at this email address?(CIRCLE) YES NO

Referred by _____

Preferred payment method (please circle): check cash credit/debit

Please provide credit/debit card information below to keep on file even if this is not your preferred method of payment. You credit/debit card will NOT be charged unless there is a cancellation fee or outstanding balance.

Circle Card Type: MC VISA AMEX Discover

Exp _____ Card # _____ CVV Code _____

PRINT Name as it appears on credit card _____

When alternate payment is not provided, Jennifer Battaglino, LCSW has permission to charge my credit/debit card for attended sessions and cancelation fees if they apply.

Signature _____

Medications, Herbs, and Supplements being used as well as prior to onset of reason for appointment:

Reason for initial visit: