COGNITIVE BEHAVIORAL THERAPY
TRAINOR
CENTER

Patient Registration Form

Please print, complete, and bring the following form with you to your first appointment at Dr. Trainor's Office located at 154 East Central Street, Suite 201A in Natick, Mass. Thank you.

– All fields are required. –

Patient's Name: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Phone Number: ______________________________

Cell Number: ______________________________

Email Address: ______________________________

Patient's Date of Birth: ______________________________

Primary Insurance Holder's Name: ______________________________

Primary Insurance Holder Date of Birth: ______________________________

Insurance Name: ______________________________

Insurance Address (located on back of your card): ______________________________

Phone Number (located on back of your card): ______________________________

ID Number: ______________________________

Subscriber Name: ______________________________

Employer: ______________________________

If you were referred to the TRAINOR Center, please provide referral name and contact information below:

Referral Name: ______________________________

Phone: ______________________________ Cell Phone: ______________________________

☐ BY CHECKING THIS BOX, I GRANT DR. TRAINOR AND THE TRAINOR THERAPISTS PERMISSION TO BILL MY INSURANCE PROVIDER FOR SERVICES. I AGREE TO PAY THE BALANCE THAT INSURANCE DOES NOT COVER. I AGREE TO GIVE 24 HOURS' NOTICE FOR ANY CANCELLED APPOINTMENTS OR I WILL PAY FOR THE FULL SESSION FEE.