



REGISTRATION

HEALTH PROFESSIONAL REFERRAL

Name:.....

Address:.....

City, State, Zip:.....

Date of Treatment Group:.....

Phones:

Home:

Cell:

Work:

Email:

Payment enclosed: \$375

Check/Money order MasterCard Visa

Credit card #:.....

Expire date:.....

3 digit code on back of card:.....

Signature:.....

I grant permission for Reid Wilson, Ph.D. to discuss my treatment with the health professional who signed my referral form. This permission expires 15 days after completing treatment group.

Today's date:.....

Signature:.....

The following person is registering for a 2-day psycho-educational and treatment group and must be referred by a health professional who has conducted at least a diagnostic evaluation.

Patient name:.....

Date of most recent diagnosis:.....

Diagnosis:

panic disorder

social anxiety disorder

obsessive-compulsive disorder

other:.....

Other information?.....

Health Professional's:

Signature:.....

Name:.....

Degree:.....

Address:.....

Phone:.....

Email:.....