Anxiety Disorders Treatment Center
Suite 110
5003 Southpark Drive
Durham, NC 27713
Phone: 919-942-0700
Fax: 866-774-9511
www.anxieties.com
e-mail: drwilson@anxieties.com

Registration

2-Day Treatment Group

Date of group:

Attendee Information

Name:
Address:
State/Province:
Zip/Postal Code:
Country:
Email:
Home Phone:
Cell Phone:
Work Phone:

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.

Signature
(type in name)

today's date

Registration Fee: $375

Payment

◯ Check payable to: Anxiety Disorders Treatment Center

◯ Credit Card

☐ Mastercard

☐ Visa

Card Number:

Expiration Date: 3-digit security code:

Cardholder Name:

Cardholder Signature
(type in name)

today's date

You may e-mail, fax or mail this form to me.