Lisa Burroughs, Psy.D.

500 Creek View Road, Suite 109
Newark, DE 19711
(302) 454-8010

Patient Information

Name _____ Home Phone _____

Address _____ Work Phone _____

_____ Cell Phone _____

Preferred Contact For VM: Home Work Cell E-mail

Emergency Contact _____ Emergency contact's phone #_____

Date of Birth _____ Family Physician _____

Phone Number _____

Who referred you? _____

Insurance Information

Member Name _____ Insurance Company _____

Member ID _____ Phone (on Back of Card) _____

Group Number _____ Employer _____

Person Responsible for the Bill (if other than self):

Name _____ Home Phone _____

Address _____ Work Phone _____

_____ Cell Phone _____

Relationship to Patient: Spouse Parent Other _____

☐ I understand that I am responsible for the payment of my bill in full. If I plan to submit my expenses to insurance, I can request a receipt with the required information.

☐ I also understand that a minimum of 48 hour notice must be given to cancel an appointment or I will be responsible for payment in full at the next appointment.

Signature _____ Date _____