Client Information

Client's Name_____ Date of Birth ___/___/___
Social Security No._____
Address_____ City_____ State _____Zip _____

Home Phone (_____)_____ Work Phone (_____)_____

Employer_____
Address_____ City_____ State _____Zip _____

Responsible Party_____ Relationship to Client: Spouse/Child/Other
Social Security No._____ Date of Birth ___/___/___
Address_____ City_____ State _____Zip _____

Home Phone (_____)_____ Work Phone (_____)_____

Employer_____
Address_____ City_____ State _____Zip _____

Consent for Treatment

By my signature below, I authorize _____ to provide psychological services to me. I am entering into treatment voluntarily and understand the limitations and risk of treatment are minimal.

_____ _____
Signature of Client **Date**

OR

Consent to treat a Minor

By my signature below, I , the parent or legal guardian of _____ authorize _____ to provide psychological services to this minor.

_____ _____
Signature of Parent/Legal Guardian **Date**

IN CASE OF EMERGENCY, PLEASE NOTIFY:
Name:_____
Relationship to Client: Spouse / Child / Other
Home Phone (_____) _____
Work Phone (_____) _____

Client Information — Psychological Services Fee Structure

_____

Client Name

The customary codes and charges are:		
Code	**Service**	**Fee**
90801	Initial Consultation	175.00
90804	Individual Therapy (30 Min.)	75.00
90806	Individual Therapy (45-50 Min.)	135.00
90808	Individual Therapy (90 Min.)	185.00
90847	Family Therapy per Hour	135.00
90853	Group Therapy	65.00
96101	Psychological Evaluation per Hour	165.00
96118	Neuropsychological Evaluation per Hour	175.00

Our office staff will bill your insurance companies. Co-pays (co-pays include but are not limited to traditional co-pays as well as co-insurance and deductibles) are due at the time of service. It is the client's responsibility to make sure that our office has the most current copy of insurance coverage cards. Unpaid insurance balances are the responsibility of the client. A Five Dollar ($5.00) monthly rebilling fee will be charged to unpaid balances past 30 days of the initial statement.

Overpayments by client or insurance companies will be refunded to the appropriate party by the doctor promptly after review of client account.

Your Co-pay amount is estimated as follows:

1st *Visit:*
Annual Deductible (if applicable) $_____
1st Visit Co-pay $_____
Total Due for 1st appointment = $ _____

2nd Visit: $ _____
3rd Visit : $ _____

A *Benefits Assignment*

I hereby assign all medical; and or surgical benefits, to include major medical benefits to which I am entitled, including but not limited to Medicare, private insurance and any other health plan to _____. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the insurance payment.

I have read and agree to the above terms.

_____ _____

Client Signature (Parent/Legal Guardian, if Minor) Date

INSURANCE PAYMENTS/DENIALS

Our office will verify your benefits for you as a convenience only; you are ultimately responsible to know your own benefits. When our office verifies benefits we are not always given the correct benefits, we do our best to insure that they are correct, but errors do happen. We are only able to give you the information that your insurance company gives us. We recommend that you also verify your benefits, which will help to eliminate error.

It is very important that you understand that our office can NEVER guarantee payment even after we have been told that it will be covered and/or have an authorization. Coverage is always based on medical necessity and benefits at the time of service. There is always a possibility that one or more of the dates of services could be denied leaving you a balance.

If you have any questions regarding this matter please feel free to ask, we will help to clarify any questions you may have.

By signing below you understand that you are responsible for all unpaid dates of service regardless of the reason for denial.

_____ _____

Responsible Party's Signature **Date of Service**

Please read the sections on our office's Collections Procedures.

Policies & Procedures

Delinquent Account Collection Procedure

It is the policy of this office to attempt to collect patient portion of charges for services within 30 days of receipt of insurance coverage payments. The process of delinquent account collection is as follows:

Once final insurance payments have been received and posted by our office, which usually happens within 45-90 days of first visit depending on how many insurance companies are involved, and the remaining balance is the client's, the following procedure will be activated.

1. A monthly statement of account is mailed on or near the 15th of the month.

2. A second Monthly Statement of Account is mailed on or near the 15th of the next month and a rebilling fee of $5.00 will be assessed to the account. You will have 5 days from receipt of this statement to make payment. Collection procedures will begin the 6th day.

During the collection process, you may potentially receive phone calls; a written letter or a message may be left on your answering machine.

Client accounts that have set up a payment plan with this office and maintain regular monthly payments will not be subjected to the Delinquent Account Collection Procedure specified above or the five-dollar monthly rebilling charge. However, if a client account with a payment plan fails to make a payment without contacting our office, the above Delinquent Account Collection Procedure will automatically go into place without notice to the client.

By initialing below you are indicating you have read the above Delinquent Account Collection Procedure information and understand the process as outlined.
Effective Date: 04-01-2003

Initials_____