ASSESMENT AND FAMILY THERAPY OF NORTHWEST OHIO

Client Information

Client's Name:________________________________ Date of Birth __/__/__ Age:_____________

Address:____ City _____________Sate_____ Zip________

Home Phone:_______________ Work Phone: _______________Cell Phone:______________

Employer ____

Address____ City_________________ State_____ ZIP________

Responsible Party

Responsible Party:____________________________ Social Security Number:_______________________

Relationship to Client:_________________________ Insurance Company__________________________

Home Phone:___________________ Work Phone: _____________________ Cell Phone:________________

Employer ____

Address____City_________________ State_____Zip____________

Consent for Treatment

Check One:

Self: _______ By my signature, I hereby authorize ____________________________to provide psychological services to me. I am entering into treatment voluntarily and understand the limitations and risk of treatment are minimal.

Minor: ______ By my signature, I, the (Circle) parent or legal guardian of _______________________hereby authorize _____________________________ to provide psychological treatment to this minor.

Client/Parent/Guardian Signature ________________________________Date______________

Emergency

In case of emergency please notify: Name: __________________________Relationship to Client________________

Home Phone: ________________ Cell Phone_______________ Work Phone: _________________

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Client Information Psychological Fee Structure

Code	Service	Fee
90791	Initial Diagnostic Evaluation	$200.00
90832	Psychotherapy (30 minutes)	$ 90.00
90834	Psychotherapy (45 minutes)	$160.00
90837	Psychotherapy (60 minutes)	$190.00
90846	Family Psychotherapy (30 minutes)	$ 90.00
90847	Family Psychotherapy (45 minutes)	$160.00
90849	Family Psychotherapy (60 minutes)	$190.00
90839	Crisis therapy (60 minutes)	$190.00
90840	Crisis Therapy (90 minutes)	$230.00
90853	Group Psychotherapy	$ 80.00
96101	Psychological Testing (per hour)	$180.00
96118	Neuropsychological Testing (per hour)	$190.00
96118	Apshsia Testing (per hour)	$190.00
Nonbillable Insurance	Achievement Testing (per hour)	$180.00
Nonbillable Insurance	Report Writing (per hour)	$150.00

Our office staff will bill your insurance company. Co-pays (co-pays include but are not limited to traditional co-pay, as well as co-insurance and deductibles) are due at the time of service. It is the responsibility of the client to make sure that our office has the most current copy of insurance coverage cards. Unpaid insurance balances are the responsibility of the client.

Over payments by clients or insurance companies will be refunded to the appropriate party by the doctor after review of the client account.

Your co Pay is estimated as follows.

1st Visit:

Annual Deductible (If applicable) ____________________

1st Co Pay Visit ___________________

Total due for 1st Appointment ___________________

2nd: Visit __________________ 3rd Visit and after: _____________

I have read and agree to the above fee structure.

__________________________________ ________________________

Name of Client/Parent/Legal Guardian **Date**

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Benefits Assignment

I hereby assign all psychological benefits to include major medical benefits to which I am entitled including but not limited to Medicare, private insurance and other health benefit plans to (Circle) **Dr. Ellenwood, Simon, Lawrence.** This assignment will remain in effect by me until revoked in writing. A photocopy of this assignment is considered to be 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 the psychologist's office to release all information necessary to secure the insurance payment.

I have read and agree to the above fee structure.

______________________________ _____________________

Name of Client/Parent/Legal Guardian **Date**

Policies and Procedures Delinquent Accounts

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 in full payments. Any balance due after insurance payment in full is the client's responsibility. After thirty days of non-payment from a statement mailed, your account will be considered delinquent.

The following procedure will be activated:

1. A monthly statement of account is mailed on or near the 15th of the month and payment will be expected within 30 days.
2. A second monthly statement of account will be mailed the 15th of the next month and an interest charge of 5 % will be assessed to the account.
3. If payment is not received within 15 days, collection procedures will begin on the 16th day by an outside collection agency.
   During the collection process, you may potentially receive reminder phone calls, a written letter or a message maybe left on your answering machine or cell phone.

Payment Plan

If for some reason, you are unable to pay in full your account balance a payment plan can be developed and collection procedures will not be initiated. However, if a payment plan is initiated and the client fails to make a monthly agreed upon payment and does not inform our office, the above Delinquent Account Collection Plan will automatically go in place without notice to the client.

By initiating below, you are indicating you have read the above **Delinquent Account Collection Procedure and Payment Plan** information and understand the process as outlined.

______________________________ _____________________

Name of Client/Parent/Legal Guardian **Date**

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Insurance Estimation of Payments

Our office staff will verify your benefits as a convince only; you are ultimately responsible to know your own benefits. When your benefits are verified we are not always given the correct benefit information, we will do our best to ensure the quote provided to you is correct but misinformation from insurance companies does happen. We are only able to give you an ***estimation*** of service cost based on the information that your insurance company provides to us.

It is very important that you understand that that our office can **NEVER guarantee** payment by your insurance company even when we are told that that service is partially or totally covered and have an authorization. Coverage is based on medical necessity and benefits at time of service. Often insurance companies will deny coverage due to lack of medical necessity after they review the claim and service has been provided. There is always a possibility that one or more of the dates of service could be denied leaving you a balance regardless of reason for denial.

You do have a right to appeal in writing within 30 days your insurance companies' decision. Please note it will be your responsibility to question and repeal your insurance company's payment decision. Our office will assist, if they are able.

If your insurance coverage runs out before services end or a balance is due, a payment plan can be arranged.

Information Required to Share with Insurance Company

Some insurance companies require that information regarding services to you be provided to them. After your first, our psychologist will need to provide a clinical diagnosis. Also at times, treatment plans, summaries of service, psychological/neuropsychological reports or entire records may be requested. We will do our best to provide only minimal information as information shared becomes part of your insurance medical records and confidentiality cannot be guaranteed by us. Please note we have no control of the type information requested and how it is handled or stored once released. Our office staff will inform you if information is requested.

Please know you have the right to pay for our services yourself to avoid confidentiality problems or the request of personal information described above unless prohibited by your insurance contract.

By signing below indicates that you have read the above information, understand and agree to its terms and acknowledges that you have either received (please request) or read on the *AFT webpage* the **OHIO HIPPA Notice and the Psychotherapist-Patient Service Agreement** Form overviewing all office policies and psychological services, limits of confidentiality etc.

________________________________ ______________________

Name of Client/Parent/Legal Guardian **Date**