Client Information

Date_____ Form completed by _____

Client Name _____DOB _____ Age_____ Sex ___

Address _____Town/Zip _____

Home phone _____ Cell phone _____ Work phone _____

Employer _____

Who referred you to this office? _____
May we thank them for the referral? _____yes _____ no

Their address_____

Emergency contact _____ Relationship to you _____

Phone number _____

Billing Information

Bills to be sent to (if other than client):

Name _____Relation to client _____

Address _____Town/State/Zip_____

Home phone _____ Cell phone _____ Work _____

Primary Insurance Information

Insurance company _____ Phone _____

Insured Name _____ DOB _____ Sex _____

Policy # _____ Group # _____ Employer _____

Client's relationship to Insured (please circle one) Self / Spouse / Child / Other

Secondary Insurance Information

Insurance company _____ Phone _____

Insured Name _____ DOB _____ Sex _____

Policy # _____ Group # _____ Employer _____

Client's relationship to Insured (please circle one) Self / Spouse / Child / Other

I authorize the release of any medical records or other information necessary to process this Claim. I also request payment of government benefits to myself or to the party who accepts Assignment.

Signed _____Date_____

I authorize payment of medical benefits to the undersigned physician or supplier of services.

Signed_____Date_____

CONSENT TO TREATMENT

I voluntarily consent to be treated by the therapist whom I have chosen or been assigned to work with in therapy. I affirm that I have been given no guarantees as to the result which may be obtained through treatment. Although it is generally recommended that I continue in therapy until the goals that I and my therapist have mutually agreed upon have been substantially achieved, I also understand that I may leave treatment at any time by my own decision. Unless otherwise specified, this authorization may be withdrawn by me at any time by so notifying my therapist.

_____ Date _____
Client/ Guardian Signature

PAYMENT POLICIES

1. Your payment or co-payment is due at the time of service. All payments are made out to your individual treatment provider. All outstanding balances not covered by your insurance company must be paid in full within thirty (30) days of receiving our bill. Any unpaid balance will be turned over to collections one hundred twenty (120) days after the date of your original bill. If you are having problems paying your bill, please call our office to discuss a payment plan.

2. As a courtesy, we will submit your insurance claims and we will assist you in working with your insurance company, but it is your responsibility to understand your particular insurance contract. Your insurance is a contract between you, your employer, and the insurance company. There are exclusions and restrictions they have placed on your coverage. Not all services are a covered benefit in all contracts.

3. **You will be charged the full amount of the visit for all missed appointments and cancellations without 24 hour notice. This is not payable by your insurance company and will be due at your next visit.** We understand that emergencies and severe weather can prevent proper notice, and these cases can be discussed with your individual practitioner.

4. If you are a divorced parent bringing in your child for treatment, you are the responsible party to this office. You may have legal agreements that someone other than yourself is ultimately responsible for medical costs for your children. If you do not want to be the party responsible for all costs, please collect the fee from the party you consider responsible prior to the appointment so you can pay us at the time of the services.

5. You may be charged a $25.00 fee per 15 minute phone consultation.

6. If you request our attendance at a meeting (e.g. PPT's, discharge conferences, etc) a fee for our attendance will be based on our hourly rate.

I HAVE READ THE PAYMENT POLICIES DESCRIBED IN THIS FORM. I AGREE TO ABIDE BY THE TERMS OUTLINED. I UNDERSTAND AND ACCEPT MY FINANCIAL RESPONSIBILITIES TO EAST LYME PSYCHOLOGOICAL ASSOCIATES.

Client's Name

Signature (Responsible Party) Date