PsychOne, PC

PATIENT INFORMATION FORM

Patient First Name:_____Middle Initial:_____Last Name:_____

Street Address:_____City:_____ State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____Office Phone:_____

Birthdate:_____ SS#:_____Age:_____Sex:_____Marital Status:_____

Home E-Mail Address:_____

What is the best number to call to leave a confidential message?_____

How were you referred to Psych One:_____

Name and Address of Billing Party (if different than above)

Name:

Street Address:

City: State: Zip:

If you use email to contact Psych One, we cannot guarantee patient confidentiality, nor can we ensure receipt and reading of the message by the intended recipient.

I, as the patient, hereby give permission for Dr. _____ of Psych One to provide counseling for myself.

Name_____ Date_____
(Signature of Patient)

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If patient is a Minor, I, as parent or guardian, hereby give permission for Dr. _____ of Psych One to provide counseling/testing for my child/children listed above.

Parent or Guardian Signature_____ Date_____

Parent or Guardian Signature_____ Date_____

⇨ **OVER**

130 Harrison Street Barrington, IL 60010 P. 847-382-5688

PsychOne, PC

Insurance Information:

1. Name of Insurance Company?_____

   ID#_____Group #:_____

2. Address of insurance carrier:_____

3. Name of insured:_____DOB:_____SS#_____

4. What is the amount of your co-pay due at time of each visit?

Our Financial and Office Policy:

1. **All counseling sessions are 45- 50 minutes in length.**

2. **Payment is expected at the time of each visit if we are not filing insurance or if you are self-pay. If filing insurance, co-pays are expected to be paid at the time of each visit.** Payment can be made by cash, check or credit card (Visa, MasterCard, and Discover Card). You will receive a monthly billing history that you can submit to your Insurance Company for reimbursement if you are going to submit a claim for yourself.

3. ***We charge for appointments that are missed or cancelled with less than 24 hour notice. These charges are not covered by insurance and will be the patient's responsibility.***

4. If you request your records be sent to another physician, therapist or school, a case summary report is prepared, the expenses for which are your responsibility and will be charged at the discretion of your treating psychologist.

5. ***IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE COMPANY PRIOR TO YOUR FIRST VISIT IN ORDER TO CHECK ON YOUR OUT-PATIENT MENTAL HEALTH BENEFITS AND ASK IF PRE-AUTHORIZATION IS REQUIRED.***

It is important that you understand and agree to our financial and office policy. Please call if you have any questions, 847-382-5688.

I have read and understand the above financial and office policies, to which I agree.

Name_____ Date_____
(Signature of Patient or Parent/Guardian if Minor)