PsychOne

NEW PATIENT INFORMATION

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Street Address:_____City:_____State:____Zip (+4): _____

Home Phone:_____ Cell: _____

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

E-Mail Address: _____

Current Insurance Company: _____

ID#:_____Group#: _____

Primary Insured Name:_____Date of Birth: _____

Address if Different from Above: _____

Do you have a co-pay?_____If yes, what is the amount per visit? _____

Office and Financial Policies:

1. You must consent for services for yourself or have the legal right to authorize consent for your dependent at PsychOne. For minors 17 & under, consent of all guardians is required. Appointments may include evaluation, psychotherapy, or psychological testing.
2. To provide a collaborative management of care, there may be communication within PsychOne, including clinicians and office personnel.
3. All counseling sessions are 45-55 minutes in length.
4. **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.
5. ***We charge $180.00 (the full visit fee) 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.***
6. 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.
7. ***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.***

I have read, understood, and agree to the consents and authorizations above regarding my responsibilities as a patient receiving services from clinicians at PsychOne, PC. For patients 17 & under, consent for treatment signatures for both parents are required below.

_____ _____
Signature of Patient (age 12 and older) Date

_____ _____
Signature of Responsible Party/Guardian #1 (if different than patient) Date

_____ _____
Signature of Guardian/Parent #2 Date