

New Patient Information

Confidential

Date: _____

Patient Name: _____ SSN: _____ - _____ - _____
Last First M.I.

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Ext: _____

Cell Phone: (____) _____ - _____ E-mail: _____

Is it OK to call and leave a message at these numbers: yes no

Gender: Male Female Date of Birth: _____ - _____ - _____ Age: _____

Marital Status: Married Single Divorced Separated Widowed NA (child)

Employment Status: Employed Student Disabled Employed/student Unemployed

Employer (or) School: _____

Insurance Company: _____

Referral Source: _____

Permission to thank referral source? (circle one): Yes or No

Referral Type: self family spouse friend physician EAP work
 court school internet other _____

Primary Care Physician: _____ Phone: _____

Permission to communicate with PCP about your treatment? (circle one): Yes or No

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Phone: _____

For children & adolescents:

Parents marital status: never married married separated divorced widowed

Mother (or Guardian) Father

Name: _____

Address: _____

(H) Phone: _____

(W) Phone: _____

Custody Arrangement (for divorced/separated parents):

informal (no court order) joint legal custody sole legal custody (mother)

sole legal custody (father) other: _____

Primary residence of child is with: _____

Consent to Treatment & Evaluation

Obligations of Treating Provider

We will treat with great care all the information you share with us. It is your legal right that our sessions and our records about you are kept private. That is why I ask you to sign a "release-of-records" form before we can talk about you or send my records about you to anyone else. In general, we will tell no one what you tell us in confidence. We will not even reveal that you are receiving treatment from us without your prior written permission to do so.

In all but a few rare situations, your confidentiality (that is, your privacy) is protected by state law and by the rules of our profession. Here are the most common cases in which confidentiality is *not* protected:

1. If you were sent to us by a court or an employer for evaluation or treatment, the court or employer expects a report from us. If this is your situation, please talk with us before you disclose anything you do not want the court or your employer to know. You have a right to disclose only what you are comfortable with sharing.
2. Are you suing someone or being sued? Are you being charged with a crime? If so, and you tell the court that you are being seen here, we may then be ordered to show the court our records. Please consult your lawyer about these issues.
3. If you make a serious threat to harm yourself or another person, the law requires that we try to protect you or that other person. This usually means telling others about the threat. We cannot promise never to tell others about threats you make.
4. If we believe a child has been or will be abused or neglected, we are legally required to report this to the authorities.

Consent to Treatment

I do hereby seek and consent to take part in the treatment or evaluation of myself or my child. I understand that developing an initial treatment plan or goals for the evaluation and regularly reviewing our work toward meeting the treatment goals are in my best interest; and I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of my treatment or evaluation; or of any procedures provided by Psychology Associates of Chester County contracted employees of the practice.

Your Rights

I am aware that I may stop my treatment with my therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) I also have the right to ask questions about my therapist's clinical background and qualifications or questions about any procedures or methods used in treatment, as well as, information about alternative methods of treatment.

My signature below shows that I understand and agree with all of these statements.

Signature

Date

Printed name

Parent or Guardian (If necessary)

PAYMENT AGREEMENT

Self-Pay Fees

- Initial Diagnostic Assessment & Evaluation: \$150
- Individual, Couples or Family Session (45 Minutes): \$125
- Group Session (60 Minutes): \$60
- Psychological Testing/ Assessment: \$150 Per Hour
- Court related work including preparation of letters and evaluations, testimony, travel time, time away from office due to legal proceedings and review of records for legal purposes: \$175 Per Hour

Fee Reduction (If applicable): _____ Provider's Initials: _____

Insurance Payment

If you are using your insurance to pay for services, it is your responsibility to be aware of your policy benefits and limitations. Please provide your insurance card at your initial appointment. Copayments are due at the

INSURANCE COMPANY: _____ (Please provide a copy of your card)

Co-Pay or Co-Insurance due each session (If known) \$ _____ % _____

It is your responsibility to be aware of your policy benefits and limitations for services rendered as well as to verify that we are in network with your insurance plan. As a courtesy to you, we may contact your insurance company to verify your eligibility for benefits. Services provided in good faith will be billed directly to you if later determined that your policy has expired, lapsed or does not cover the requested service. Please note that some insurance companies require pre-certification of services and may require personal information related to your diagnosis and treatment plan. Please refer to the "Notice of Privacy Practices" or "HIPPA Notice" for more specific information. This is available online at: www.chestercountypsychology.com on the "Resources" page. You are entitled to receive a paper copy upon request.

If you are using an "out of network" benefit you will be responsible to pay the self-pay fees listed above, (unless otherwise prohibited by your insurance plan) or a designated co-pay or co-insurance amount determined by your policy benefits. As a courtesy to you, we will submit insurance claims on your behalf or provide you with a statement for any services rendered to submit to your insurance company. Under either circumstance, you will be reimbursed according to your insurance benefit for "out of network providers" or "non-participating providers".

Fee Arrangement: I understand that unless other arrangements are made, fees are due as stated at the beginning of each session. Currently we accept cash or check only.

Missed Appointments: I agree to accept financial responsibility for any missed appointments not cancelled within 24-hours or my scheduled appointment time. **The missed appointment or late cancellation fee is \$ 50 and is not billable to my insurance company.**

Non-payment: I also acknowledge that my account will be referred to IC System, a national collection agency if my account becomes 45 days past due. Please be aware that if your account continues to be unpaid IC System is authorized to report all outstanding debts to the four major national credit agencies and may pursue litigation to recover your debt (other legal fees may apply).

Additional Cost of Collection Services:

Invoices shall be deemed to be accepted by you unless we are notified in writing within 14 days of the invoice being issued that you dispute the amount of the invoice. In the event of non-payment, we may in addition to the invoice amount charge:

- i. Interest on any outstanding amounts from the date due calculated at the statutory penalty rate of 6%
- ii. Legal and debt collection fees incurred by Dr. Given's practice in relation to the recovery of outstanding amounts.

I authorize the release of information necessary to process insurance claims, and assign my benefits directly to Psychology Associates of Chester County.

If paying by check, please make checks payable to: Psychology Associates of Chester County

Please note that you will be responsible for any bank fees for returned checks.

I have carefully read all the terms of the above guidelines and agree to abide by its guidelines. I have had an opportunity to ask questions acknowledge that I may receive a copy of this agreement.

Signature of Patient/ Responsible Party

Date