Today's Date:	Do you see more than 1 provider at this location?: ☐ Yes ☐ No

PATIENT INFORMATION

Patient's Last name:	First:	Middle:

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security no.:	Birth date:	Age:	Sex: ☐ M ☐ F

Mailing Address:

Street/ PO Box/ Apt. #:	City	St	Zip Code

Cell phone no.: ☐ Check if it is NOT ok to leave a message ☐ Check if you wish to receive reminders via text	Home phone no.: ☐ Check if it is NOT ok to leave a message	Email: ☐ Check if you wish to receive reminders via email
Parent/ Legal Guardian name:	Birth date:	Soc. Sec. #:

Allergies:

Preferred Pharmacy Name:	Address:	Telephone no.:

RESPONSIBLE PARTY INFORMATION

Name of person responsible for payments:	Birth date:	Address (if different than patient's):	Primary phone no.:

Relationship to patient: ☐ Parent ☐ Guardian ☐ Other _____

Is the patient covered by insurance? ☐ Yes (continue to next section) ☐ No (skip Insurance Information section)

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist.

Name of PRIMARY insurance company:

Subscriber's name:	Subscriber's Soc. Sec. #:	Birth date:	Policy #:	Group #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of SECONDARY insurance company (if applicable):

Subscriber's name:	Subscriber's Soc. Sec. #:	Birth date:	Policy #:	Group #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Cell phone no.:

Patient/Responsible Party Signature **Date**

Patient Name (Print)**:**_____

APPOINTMENT and CANCELLATION POLICY

You agree to the appointment times the office staff and the provider of services schedules especially for you. Failure to keep an appointment not only results in a loss of revenue to the provider, it prevents another patient from being scheduled for that same time. Our providers have waiting lists for those who are seeking appointments. As a courtesy to you, we try to make appointment reminder phone calls the day prior to your visit. However, the policies below will apply even if we are unable to contact you due to office time constraints.

We expect you will keep your scheduled appointment and give us at least 24 business hours' notice when it is necessary to change your appointment to enable us to schedule someone else. As the office is closed weekends and holidays, it is necessary to notify us in time for us to schedule another patient.

Our policy regarding late cancelled or missed appointments is as follows:

- A patient with a scheduled appointment must call at least 24 business hours in advance of the appointment to cancel or reschedule**.** For Monday appointments, we must receive notice of cancellation by Friday the same time.
- **Cancellations with less than 24 hours' notice will result in a fee of 50% of the full hourly rate being charged. Missed appointments will result in a charge of the regular full-hourly rate. Forensic services are billed at $250 per hour and in 15 minute increments with a minimum of 2 hours and must be prepaid. Writing of professional letters are billed at $250 per hour and billed in 15 minute increments. Medical Evaluations are billed at $150 per hour and must be prepaid.** I have been informed of my provider's current hourly rates and fees and understand they are subject to change.
- A missed appointment or cancellation charge applies for ***EACH*** occurrence**.** After the **third occurrence,** with less than the required 24 business hours' notice, the provider of service will determine if this will result in a discharge from service. You will be notified if this is the case.
- We are aware that at times, it is just not possible to give 24 hours' notice. The decision to waive the fee for extenuating circumstances resulting in the cancellation or missed appointment will be up to the individual provider only.

I have read and understand the Appointment and Cancellation Policy:

_____ _____

Patient/Responsible Party Signature **Date**

NOTICE OF PRIVACY PRACTICES

I, _____, have been advised of and have read the **NOTICE OF PRIVACY PRACTICES (NPP).** I understand that a copy of this notice can be provided to me upon request.

I hereby authorize _____ to release information for the purposes outlined in the
(Provider's name)

NPP statement only and release the center from any liability which may arise as a result of the use of the information contained in the copy of records released. Further disclosure is prohibited unless expressly permitted by written consent of the person to whom it pertains or as otherwise permitted.

I have read and understand the Notice of Privacy Practices:

_____ _____

Patient/Responsible Party Signature **Date**

Patient Name (Print)**:**_____

FINANCIAL POLICY

We are committed to providing you with the best possible care and service. In order to achieve these goals, we ask that you review the following information to facilitate your understanding of our financial policies. Please do not hesitate to ask questions and/or discuss any concerns.

Visit Payments: Payments, when due, are made to the provider of service on the day of your visit. We accept cash, Visa or MasterCard or check. For your convenience, we can also accept your credit card payment by phone.
Any returned checks will be subject to a $30.00 service fee to cover bank charges.

Private Pay Arrangements: Payment is due in full at the time of service unless you have made payment arrangements in advance with our business office or the provider of service.

Insurance: Your insurance plan is a contract between you and/or your employer, and the insurance company. We are not a party to that contract. All charges are the responsibility of the patient from the time services are rendered. As a courtesy to you, we will attempt to contact your primary insurance company prior to your first visit to determine mental health eligibility and benefits, including co-pays/co-insurance, any deductible amounts and any pre-authorizations required. If you have not already done so, we strongly urge you to contact your insurance company to verify your mental health benefits and any pre-authorization required. This is due to the fact that we have found on occasion that the insurance information provided to us by your insurance carrier prior to your first visit is in error. Since, you are ultimately responsible for payment, we urge you to notify us if there is a discrepancy. If we do not receive payment from your insurance company within 60 days, we will make every effort to contact them to determine the reason and resolve the issue if possible. We will notify you if your insurance indicates the claim is under review and they require additional information from you. If claims are not paid due to deductibles not met, exhausted benefits, denial of services, insurance termination or your insurance company has not paid the claim after two follow-up calls, we will transfer the charges to you. If requested, we will provide you with any documents your insurance company may require in order for them to reimburse you directly.

Co-Pays and Deductibles: We require that these be paid at the time of your visit. If an insurance deductible has not been met at the time of your initial and/or subsequent visits, we will expect payment at the time of service until your deductible has been met. We will bill your insurance company to reflect your payment(s).

Insurance Change: If there is a change in your insurance carrier or benefits, it is your responsibility to determine if a pre-authorization is required and notify us of your new insurance information prior to your next scheduled appointment. Failure to do this may result in non-payment by the insurance making it necessary to transfer the charges to you.

If at any time you want to discuss your financial obligations with us, we will be happy to make an appointment for you with a business office representative.

I have read and understand the financial policy.

_____	_____
Patient/Responsible Party Signature	**Date**

Patient Name (Print)**:**_____

A NOTE FROM YOUR PROVIDER

It is important to me that you, as a consumer, are clear about the manner in which I am able to provide service to you. Our office is structured in a fashion that permits all of us to be completely independent providers who have separate licenses with no affiliation.

We have joined our resources to employ the Counseling Center of New Smyrna Beach &/or the Center for Behavioral Medicine to handle scheduling and billing in our names. Therefore, all payments should be made directly in my name, not to the center.

As an independent practitioner, all clinical responsibility for your care is mine. If, at any time you feel that there are deficiencies in the process of your care, scheduling or billing, please bring your concerns to my attention.

Thank you for your understanding in this matter.

Please sign below indicating that you understand the above information.

I have read and understand the above statement from my provider:

_____ _____

Patient/Responsible Party Signature **Date**

AUTHORIZATION FOR VERBAL COMMUNICATION

Information to be Disclosed. Verbal communication only – no copies of records provided. The individual(s) listed in the box below have my permission to answer questions about and to discuss orally all aspects of my health information with the other individual named below.

Communication Between:		**And: (Provider's information)**	
Name:	Phone #:	Provider Name:	Phone #:
Address:	Fax #:	Address:	Fax #:
City: State: Zip Code:		City: State: Zip Code:	

5. This Authorization will remain in effect for one year from signature unless otherwise indicated below:

☐ Indefinite ☐ Ends on: (date) _____/_____/_____

I authorize both parties above to exchange information between themselves.

This information is valid from the date of signature or completion of treatment, which includes but is not limited to, final insurance billing or any pending legal cases. This authorization is subject to revocation (in writing) at any time, except to the extent, that the provider has already acted in reliance on it and/or any stipulations as provided in our New Patient Paperwork at time of signature.

Agreement: I hereby release _____(provider name) from any liability which may arise through the use of the information contained in the copies of records revealed. It will be presumed, that if this information is later used to a damaging effect upon myself, that it was obtained as a result of this authorization. I have been provided with a copy of the Privacy Policies.

_____ _____

Patient/Responsible Party Signature **Date**

Patient is: ☐ Minor ☐ Incompetent/incapacitated

Legal authority: ☐ Parent ☐ Legal Guardian

Other relationship: _____

PAYMENT AUTHORIZATION

By signing this authorization, I acknowledge that I have read and agree to all policies and warrant all information given is true in the patient packet. I understand revocation of this authorization must be done in writing in person or by certified letter.

Patient Name:		
Provider Name:		
Check One:	☐ VISA ☐ MasterCard	
Credit Card #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___		
Exp. Date on Credit Card (mm/year): ___ ___/ ___ ___ ___ ___		
Card Verification Code: (the 3 digit code on the back of your credit card): ___ ___ ___		
Name as it appears on card:		
Credit card billing address:		
City:	State:	Zip:
Telephone:		
This authorization is given to the provider mentioned above and subject to the terms of the above policies which are incorporated by reference herein.		
Printed Name of Card Holder:		
Signature of **Card Holder**: _____ Date: _____		