

CLINICAL PSYCHOLOGISTS, PC
Client Information Form

Date: _____

I. BASIC INFORMATION:

Client's Name: _____ Social's Security #: _____
Age: _____ Date of Birth: _____ Driver's License #: _____
Sex: Male _____ Female _____

Phone Numbers:	OK to leave a message?
Cell Phone: _____	Yes _____ No _____
Home Phone: _____	Yes _____ No _____
Work Phone: _____	Yes _____ No _____
Email Address: _____	Yes _____ No _____

(Only the first name of the secretary or therapist and our phone number will be given.)

Present Address:

Permanent Home Address: (if different from above)

_____ Phone: _____

Place of Employment: _____ Occupation: _____

II. ARE YOU SEEKING SERVICES FOR:

____ Yourself
____ Your Child (give age _____; **also Complete Section IV below**)
____ You and your spouse/partner/family; **also complete V below**)
____ Other: _____

Reason for Requesting Services:

Referred by: _____
Previous Mental Health Care: Yes _____ No _____
(If yes) Provider(s): _____ Date: _____
Provider(s): _____ Date: _____
Name of your Physician: _____ Phone: _____

III. PERSONS TO CONTACT IN AN EMERGENCY:

Name: _____ Relation to Patient: _____ Phone: _____
Name: _____ Relation to Patient: _____ Phone: _____

IV. INFORMATION NEEDED IF YOU ARE SEEKING SERVICES FOR YOUR CHILD

School: _____ Grade: _____ Phone: _____
Principal: _____ Special Class Placement: _____
Teachers: _____

Custodial Guardian(s): _____ **Relationship to Child:** _____

Contact Information for Parents or Primary Guardians:

Name: _____ **Age:** _____ **D.O.B.** _____

Home Address: _____ **Phone:** _____

Business Address: _____ **Phone:** _____
_____ **Occupation:** _____

Additional Parent/Guardian Information **Relationship to Child:** _____
Name: _____ **Age:** _____ **D.O.B.** _____

Home Address: _____ **Phone:** _____

Business Address: _____ **Phone:** _____

Names of Parents if different from above: Mother _____ Father _____

Marital Status of Parents: Married _____ Divorced _____ Other (explain) _____

Stepmother's Name: _____ **Stepfather's Name:** _____

Sibling's Name: _____ **Age:** _____ **Check if Half/Step?:** _____

Sibling's Name: _____ **Age:** _____ **Check if Half/Step?:** _____

Sibling's Name: _____ **Age:** _____ **Check if Half/Step?:** _____

Sibling's Name: _____ **Age:** _____ **Check if Half/Step?:** _____

V. INFORMATION NEEDED IF YOU ARE SEEKING COUPLES THERAPY

Additional Client Name: _____ **Social Security #:** _____

Age: _____ **Birth date:** _____ **Driver's License #:** _____

Sex: Male _____ Female _____

Present Address (only if different from above): _____ **Ok to leave message?**
_____ **Phone:** _____ (cell) **Yes** _____ **No** _____
_____ **Phone:** _____ (home) **Yes** _____ **No** _____
_____ **Phone:** _____ (work) **Yes** _____ **No** _____

Place of Employment: _____ **Occupation:** _____

Previous Mental Health Treatment: Yes _____ No _____ **Date(s):** _____

Treatment Provider: _____

Emergency Contact: _____ **Phone #:** _____

Client Name: _____

VI. PAYMENT & INSURANCE INFORMATION

1. Name of person responsible for payment of services: _____

Send Bill to: _____ Phone: _____
Address: _____

2. Any special billing instructions: _____

3. We must have the following information if you want us to file your insurance:

Primary Insurance Information

Secondary Insurance Information

Name of Primary Insurance

Name of Secondary Insurance

Policyholder's Full Name

Policyholder's Full Name

Relation to Patient

Relation to Patient

Policyholders Date of Birth

Policyholders Date of Birth

Social Security Number

Social Security Number

Policyholder's Employer

Policyholder's Employer

Policy/ID Number

Policy/ID Number

Group Number

Group Number

Insurance Telephone Number

Insurance Telephone Number

Driver's License # / State

Driver's License # / State

VII. FEE AGREEMENT

Billing will occur at the end of each month for psychological services at the rate of \$130.00 per 45 to 50 minute session. [Other charges: \$140.00 per hour for initial intake appointments; \$135.00 per hour for assessment (including test scoring and interpretation, report preparation, and consultation); \$10.00 - \$30.00 for records to be mailed/released. Charges for legal consultation, testimony, and telephone consultation should be discussed with your psychologist.]

I UNDERSTAND THAT MISSED APPOINTMENTS THAT ARE NOT CANCELLED 48 HOURS IN ADVANCE WILL BE CHARGED. THESE MISSED APPOINTMENTS CANNOT BE FILED WITH MY INSURANCE CARRIER AND I WILL BE HELD FINANCIALLY RESPONSIBLE.

_____ (Initials)

At your request, we will bill your insurance carrier directly. We cannot guarantee if or what your insurance will pay. It is the patient’s responsibility to know what their outpatient mental health benefits are. The patient’s share of the fee, including deductible, is due at the time of service. Payment in full, for the initial session is due at that time. Whoever is specified as responsible for the bill must pay for all fees in the event of nonpayment or reduced payment by your insurance company. Parents of college students will be billed only after they have signed a fee agreement. Should your account become delinquent, your name and other information relevant to collections may be turned over to a collection agency. You will be responsible for all collection expenses, attorney fees, and court costs expanded in the resolution of the account.

LEGAL / FORENSIC CHARGES

Depending on the forensic issue, your psychologist may not be willing to become involved in legal proceeding and may decline to do so. In the even that legal involvement concerning you does occur, charges for legal consultation and/or testimony will be billed at \$180.00 to \$250.00 per hour, to be agreed in advance in consultation with your psychologist. Insurance will not pay for these expenses and will not be filed under these circumstances. In the event that you become involved in litigation, you agree to pay at the forensic rate for all time spent by your psychologist on court related matters, including but not limited to:

1. Responding to subpoenas by attorneys for either party
2. Preparation for the case
3. Phone calls
4. Record copying and mailing
5. Time traveling to and from court
6. Time testifying in court
7. Time spent in a courthouse waiting to be called for testimony
8. Any other legal expenses incurred by the psychologist to respond to your legal case

I HAVE BEEN ORIENTED AS TO MY RESPONSIBILITES REGARDING MY FEE AND UNDERSTAND AND AGREE THAT I WILL BE RESPONSIBLE FOR PAYMENT OF THE BILL IN FULL.

Patient Signature: _____ Date: _____

Person Responsible for Payment Signature: _____ Date: _____

VIII. TO ALLOW INSURANCE TO PAY OUR OFFICE

As a courtesy, Clinical Psychologist, PC will file insurance at the end of the month after all necessary information is supplied to this office. However, we cannot guarantee payment by the insurance company. It is the patient's responsibility to keep abreast of, and notify this office of, any changes regarding insurance coverage, i.e., deductibles, percentage paid, yearly maximums, etc. If you offer health insurance as complete or partial payment of your fees, we ask that you assign the insurance payments to Clinical Psychologist, PC.

****We release only the Basic Minimum Information to your Insurance carrier in order to file your claim.**

I HEREBY ASSIGN ALL MENTAL HEALTH BENEFITS PAID BY MY INSURANCE COMPANY TO CLINICAL PSYCHOLOGISTS, PC THIS ASSIGNMENT WILL REMAIN IN EFFET UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I HEREBY AUTHORIZE CLINICAL PSYCHOLOGISTS, PC TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Patient Signature: _____ Date: _____

Person Responsible for Payment Signature: _____ Date: _____

IV. IF YOU DO NOT WANT YOUR INSURANCE FILED, PLEASE INDICATE THIS BELOW.

I do not want my benefits assigned or my insurance filed. Therefore, I am fully aware that I am responsible for all charges incurred.

Signature

Date