PFC Psychological & Family Consultants, Inc.

PATIENT INFORMATION:

Date:_____

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

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Date of Birth:_____ Age:_____ Gender Preference:_____

Social Security #:_____

Place of Employment:_____ Work Phone:_____

Employment Status: Full-Time Part-Time Retired Unemployed

Student Status: Full-Time Part-Time Not a Student

Marital Status: Single Married Separated Divorced Widowed

Name of Spouse/Partner (if applicable):_____

If Minor, Mother's Name:_____

If Minor, Father's Name:_____

Your Email:_____

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EMERGENCY CONTACT INFORMATION:

Name of Contact:_____ Relationship:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

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REFERRAL INFORMATION:

How Did You Hear About Us?_____

Referring Doctor:_____ Phone #:_____

Primary Care Physician:_____ Phone #:_____

Have You Previously Received Psychological Care? Yes No

If Yes, With Whom?_____ Phone #:_____

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PLEASE LIST THE CURRENT REASON FOR SEEKING HELP:

_____

_____

PRIMARY INSURANCE INFORMATION:

Name of Insured:_____ Relationship to Patient: _____

Address of Insured:_____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Date of Birth:_____ Age:_____ Male Female

Social Security Number of Insured:_____

Place of Employment of Insured:_____

Address of Employer:_____

Phone Number of Employer:_____

Name of Insurance Company:_____

Address of Insurance Company (to submit claims):_____

City/State/Zip:_____

Phone Number of Insurance Company:_____

Policy Number:_____ Group Number:_____

Effective Date:_____ Copayment, if known:_____

SECONDARY INSURANCE INFORMATION:

Name of Insured:_____ Relationship to Patient: _____

Address of Insured:_____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Date of Birth:_____ Age:_____ Male Female

Social Security Number of Insured:_____

Place of Employment of Insured:_____

Address of Employer:_____

Phone Number of Employer:_____

Name of Insurance Company:_____

Address of Insurance Company (to submit claims):_____

City/State/Zip:_____

Phone Number of Insurance Company:_____

Policy Number:_____ Group Number:_____

Effective Date:_____ Copayment, if known:_____

PFC Psychological & Family Consultants, Inc.

Notice of HIPAA Regulations and Consent Form

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment. Upon request, a Notice of Privacy Practices will be provided.

The Client Understands:

Protected health information may be disclosed or used in treatment, payment or health care operations. Your information will not be released to any other party unless a signed authorization form is completed, signed and witnessed by our staff. This office provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE THE RIGHT TO RECEIVE A COPY OF THE HIPAA NOTICE FORM DESCRIBED ABOVE.

If you would like to review/or pertain a copy of the HIPAA Privacy Policy, please let the front desk know.

_____ _____

Client Signature Date

_____

Relationship to Client

_____

Witness

PFC Psychological & Family Consultants, Inc.

FINANCIAL POLICY

Client Name: _____

IF YOU HAVE MEDICAL INSURANCE:
We will file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information that is provided to our office on the patient information form is accurate and current. **If there is a change in insurance information, please let us know immediately.** We will submit to secondary insurance as long as we are given the correct information and we are notified that you would like this service done.

Deductibles, Co-Payments, and Coinsurance:
Co-payments are constant and due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy.

A copy of your insurance card is required at the time of the initial service. If you don't provide your card, you may be responsible for the entire charge. The card is descriptive and indicates whether an authorization is needed. Oftentimes, the behavioral health benefits are under a separate company and we must contact them to verify the necessity of an authorization. There are timely filing limits, as well. **If a copy of the card is not on the file at the initial service and the claim is denied for "no authorization," or "timely filing," you will be responsible for the payment. It is also your responsibility to keep us updated on any changes to your insurance or you will be responsible for the full charge.**

Provider Coverage:
We are not responsible for ensuring that our provider is covered under your particular plan provision. Each insurance company has multiple plans. The provider may participate with the insurance company, but not your particular plan. Please contact your insurance company to verify that the provider you are seeing is appropriately covered. **It is ultimately your responsibility to verify coverage for your particular plan. If the insurance company denies the claim for a plan provision, you will be responsible for the balance.**

Medical insurance coverage is a contract between you and your insurance company.
WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. **You are ultimately responsible for the timely payment of your account.**

PAYMENT METHODS AND OTHER INFORMATION:
We accept cash, check and VISA/Mastercard/American Express/Discover
Accounts can be set up on payment plans, if necessary, at no additional cost.
Accounts that are past due will be turned over to our collection agency and reported to the Credit Bureau.
All late cancellations and no-shows will be billed $50 automatically. (We require 24-hour notice in advance to avoid charges.)

A SPECIAL NOTE: In situations of divorce, separation, court orders, etc., the party initiating treatment will be financially responsible for the account (including no-shows and late cancels).

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I acknowledge that I have read and agree to the above Financial Policy.

Signature: _____ Date: _____

Witness: _____ Date: _____