J. Patrick Mooney, Ph.D.

IDENTIFICATION AND INFORMED CONSENT TO TREATMENT

Patient's Name: _____ Patient's Birth Date: _____
Last First Middle MM/DD/YYYY

Address: _____
Number and Street City State Zip Code

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

E-Mail: _____

- Can all of the above phone numbers be called as needed? Yes ___ No ___ **Initials:** _____
- If no, how may I reach you on short notice? _____

Primary Care Physician: _____ Who Referred You? _____

Do you consent to me giving or exchanging your Protected Healthcare Information (PHI) with your physician to help provide, coordinate, or manage your healthcare services? Yes ___ No ___ **Initials:** _____

INSURANCE INFORMATION:

Insurance Company Name: _____

Policy Holder Name: _____ Policy Holder ID #: _____

Group #: _____ Policy Holder Employer: _____

Secondary Insurance Company Name: _____
(NOTE: Patient bills secondary unless same company as primary)

Secondary Policy Holder Name: _____

Secondary Insurance ID #: _____ Group #: _____

OTHER CONSENTS AND POLICIES:

INSURANCE ARRANGEMENTS: I consent to assign insurance payments due for services provided by Dr. J. Patrick Mooney. I acknowledge that I remain responsible for payment of any fees that insurance does not cover or will not pay. I authorize the sharing of information between Dr. Mooney and my insurance company as necessary to authorize treatment and process payments. **Initials:** _____

BUSINESS ASSOCIATES AND AGENTS: I consent to the giving or exchanging of my Protected Healthcare Information (PHI) with Dr. Mooney's business associates and agents (i.e. transcriptionists, billing personnel, and neurofeedback/testing technicians) only to the extent necessary to conduct business with them. They have signed a Business Associate Contract that requires them to keep PHI confidential. **Initials:** _____

MISSED SESSION POLICY: Patients must provide a 24 hour notice for appointment cancellations. Failure to do so will result in a $50 charge for each incidence. Insurance cannot be billed for this. **Initials:** _____

WAIVER ON FAMILY COURT ACTIONS: I waive any right to involve Dr. Mooney in any future legal child custodial dispute/evaluation or court testimony on behalf of one family member against another. **Initials:** _____

My signature acknowledges my understanding of and/or consent to: coordination with patient's physician/business associates, family court waiver, insurance arrangements, and missed session policy.

Signature: _____ Date: _____
MM/DD/YYYY