Laura Rocker M.D.
Child, Adolescent, and Adult Psychiatry

19910 Malvern Road
Shaker Heights, OH
44122
Phone: 216-765-3220
Fax: 844-364-1293

Service Agreement

Name of Client:					
Date of Birth:	Age:				
Responsible Party Name:					
Address:					
Home #:	Ok to leave a message		Yes		No
Work #:	Ok to leave a message		Yes		No
Cell #:	Ok to leave a message		Yes		No
Email:					
Occupation:					
Place of Employment::					
Who referred you to my practice?					

Payment and Health Insurance
Please read carefully! My office handles health insurance differently than many health care providers. By choice, I have not contracted with any insurance companied, and consequently I am an *out of network provider.* If you are relying on your health insurance to cover or defray the cost of services, I recommend that you check your policy's provision for out of network providers.

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Payment and Health Insurance - Continued	
I ask my clients to pay for services directly, and to submit health insurance claims for reimbursement. It will be your responsibility to manage the mechanics of your insurance claim. Accordingly, I do not accept direct assignment of payment from insurance carries. My role will be to assist you in any reasonable way possible. I will supply you with monthly HCFA (universal) health insurance claim forms, completed with all necessary provider information and codes. You can then submit these claim forms to your carrier for reimbursement. Payment is due at the time of service. I accept personal checks and credit cards	
Professional Services Agreement	
Below is a list of my fees and a summary of my billing practices. Please read this information carefully, and sign to acknowledge your understanding and acceptance of these terms.	
Cancellation Notice	
Twenty- four hours (one business day) cancellation notice is required. Should you cancel with less than a twenty-four hour notice, I will do my best to fill the appointment. If I am unable to, your account will be billed a fee for the time reserved.	
Your name (please print):	
Your Signature:	Date:

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Notice Of Privacy Practices	
Please sign below to indicate that you have been offered a copy of Privacy Practice and have read them. The Notice of Privacy Practices is available for download on my website and is also available in written form.	
Your name (please print):	
Your Signature:	**Date:**