Date copied to billing _____

Dx Code _____

FOR OFFICE USE ONLY

JOEY ADAM LERNER, MD, MPH
WADE T. MARKLAND, MD
5277 Manhattan Circle, Suite 110
Boulder, CO 80303
Phone: 303-543-5781 Fax: 303-543-5782

PATIENT INFORMATION

Patient Name: Last_____ First_____Middle Initial _____

Date of Birth_____ Home Phone_____ Cell Phone_____

Address_____ City/State/Zip_____

Email (for scheduling) _____ Gender: M ☐ F ☐ Marital Status _____

PATIENT ALLERGIES:_____

PARENT/GUARDIAN INFORMATION (for patients who are minors)

Parent/Guardian: Last_____ First_____Middle Initial _____

Date of Birth_____ Home Phone_____ Cell Phone_____

Address_____ City/State/Zip_____

Employer _____ Work Phone _____

Parent/Guardian: Last_____ First_____Middle Initial _____

Date of Birth_____ Home Phone_____ Cell Phone_____

Address_____ City/State/Zip_____

Employer _____ Work Phone _____

PRIMARY CARE PHYSICIAN

Name_____Phone_____ Fax_____

Address_____ City/State/Zip_____

REFERRAL SOURCE

Name_____Phone_____ Fax_____

Address_____ City/State/Zip_____

OTHER CONTACT INFORMATION

Current therapist's name and phone _____

Emergency contact name and phone _____

Name, address & phone of nearest relative not living with you _____

INSURANCE INFORMATION (Needed for prescriptions)

Policy Holder Name_____DOB_____Relationship to Patient_____

Policy Holder Employer_____Policy Holder Soc. Sec.#_____

Insurance CO Name_____Member ID_____

Ins. Co. Address_____Ins. Co. Phone _____

RX BIN_____RX PCN_____

*******PLEASE COMPLETE SIDE 2*******

CONSENT AND CONTRACT FOR EVALUATION AND TREATMENT

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. In consideration for receiving services we require you to read and sign the following:

FEE PAYMENT POLICY: Full payment of professional fees is required at the time of service. We accept cash, checks, and credit cards. Returned checks will be assessed a $25 fee. If payment is not made at the time of service, a $20 billing charge/late fee will be assessed. A rebilling fee of $10.00 per month will be charged for any self-pay balance due over 30 days on your account. If payment is not received in 60 days, the account will be turned over to a collection agency. The minimum additional collection fee is 50% of the total account balance.

- **All patients are required to authorize use of a current credit card which may be used to pay for charges incurred (sign authorization below).**

You are responsible for all charges for professional services rendered on behalf of the identified patient regardless of insurance coverage. Please be aware that services not covered by your insurance may include missed appointments and services provided outside of scheduled appointment times such as telephone calls, letters, reports, faxes, copying of records, or consultations with other providers (doctors, pharmacists, insurance companies, teachers, therapists).

TELEPHONE CALLS AND LETTERS: We attempt to respond within a reasonable time to requests for return calls or letters. Please understand that during business hours our priority is treating patients in the office, which may cause delays in responding. There is no fee for brief calls or calls related to scheduling. Letter preparation and other calls lasting over 5 minutes may incur prorated fees based on time with a minimum charge of $25.

CANCELLATIONS AND MISSED VISITS: Unless cancelled at least twenty-four hours in advance (by noon of the preceding Friday for Monday appointments), our policy is to charge for cancelled and missed appointments at the rate for that visit. Please remember your scheduled appointments.

NOTICE: Patients who do not have a scheduled appointment or have not been seen in the last 6 months will be considered inactive and your chart will be closed.

Thank you for understanding our policies. Please let us know if you have questions or concerns.

AGREEMENT TO TERMS OF SERVICE: I have read the preceding information. I understand and agree to this evaluation and treatment contract. I consent to the evaluation and treatment of the identified patient. I understand that I am financially responsible for services provided and for any collection fees, attorney fees or court costs associated with use of outside agencies required for collection of my account.

Patient Signature (if over 15)_____Date _____

Responsible Party Signature_____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

❒ I authorize the release of the above provided information and any medical information necessary to 1) provide for adequate professional coverage in the absence of Drs. Lerner and Markland.

❒ I authorize Drs. Lerner and Markland to speak with and/or write a report to my referring doctor/therapist

❒ I grant permission to request any medical records regarding my medical history including psychiatric records.

Patient Signature (if over 15)_____Date _____

Responsible Party Signature_____ Date _____

PRE-AUTHORIZED/GUARANTEED CREDIT CARD PAYMENT

I authorize Drs. Lerner and Markland to keep my signature on file and to charge my credit card for any charges as specified in the treatment contract. Card type (check one): Visa ☐ MasterCard ☐ AmEx ☐ Other ☐

Card Number _____ Expiration Date_____3-digit code_____

Cardholder Name _____ Cardholder Signature_____

Billing Address & Zip Code _____Today's Date _____