ΨMEDICAL PSYCHOLOGY ASSOCIATES

MEDICAL PSYCHOLOGY~ NEUROPSYCHOLOGY & ASSESSMENT~ FORENSIC PSYCHOLOGY

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Patient/Client Information

Patient/Client Name: _____ **Date:** _____
***Preferred Phone #:** _____ **E-Mail Address:** _____
*We will use this number for routine matters, such as schedule changes, reminder calls, etc.

Consent for Psychological Services

Your Signature Below Confirms Your Understanding & Consent of the Following Policies

- I have read and understand the ***Mandatory Provider Disclosure Statement*** included in this intake packet, which also includes Privacy and Confidentiality Information.
- I fully authorize the release of all necessary and relevant information back to the agency or provider who requested, ordered or are paying for such services and referred you to MPA to provide such services.
- I agree that any services provided by MPA may be terminated if I am untruthful about medication use, provide misleading or incorrect information regarding the nature of services requested (Insurance/Billing Fraud), or engage in abusive of threatening interactions with MPA staff or providers.

Please Initial Each Box to Indicate Understanding & Consent

Alternative Communications Agreement

☐ I authorize staff and/or providers at MPA to utilize alternative communication sources, including ***text messaging*** (cell phones), ***messaging services or applications (***cell phone & computer based), ***and HIPAA compliant remote video streaming services such as ZOOM*** as necessary and/or requested to provide enhanced and expedited communication and/or an alternate means of providing psychological services.

Payment & Insurance Agreements

☐ I understand that the fees for the initial appointment, and subsequent appointments will vary depending upon the service being provided. Fees for services are available upon request.

☐ I understand that **MPA** may file claims on my behalf and will accept third party payments for my account. However, I am ultimately responsible for all payment of services including, co-payments or unpaid balances on my account, subject to the terms of any agreement **MPA** may have with my insurance provider.

☐ I authorize the release of all necessary information required in order to process insurance or collection claims, and I authorize payment of claims directly to **MPA.** I give **MPA** permission to submit my name and account information to a third party for collection of past due amounts for which I am responsible.

Printed Name: _____

Signature: _____

I agree to pay fees: ☐ in full at time of service, or ☐ full co-pay at time of service

All individuals signing this document will be required to provide Medical Psychology Associates with current credit card (VISA, Mastercard, American Express) or employer funded HSA Account card information to be used for any service co-pays, unpaid balances or unforeseen but necessary services. ***Please provide your information below then allow Dr. Wylie to photocopy both sides of the same card.***

Card Type:_____ **Name on Card**: _____

Card #: _____ **Billing Zip Code**:_____

Security #: _____ **Expiration Date**: _____

Patient/Client Information

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **SSN #:** _____

E-Mail: _____

Primary Insurance

Insurance Company: _____

Insurance Policy #: _____ Group **#:** _____

Guarantor Name: _____ Guarantor's **DOB**: _____

Relationship to patient: _____