PATIENT INFORMATION FORM-PSYCHOLOGIST

DATE: _____

PATIENT NAME: _____ CHILD / ADULT (please circle)

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PATIENT DATE OF BIRTH: _____

HOME#: _____ CELL#: _____

EMAIL: _____ PATIENT MARITAL STATUS: _____

REFERRING PHYSICIAN/PERSON: _____

Was patient or family previously seen at Short Hills Associates? YES_____ NO_____

PERSON RESPONSIBLE FOR PAYMENT: (If same as above disregard)

NAME: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ EMAIL: _____

HOME#: _____ CELL#: _____

NOTIFY PERSON IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____

PHONE(S):_____ ADDRESS_____

EMPLOYMENT DATA:
(If the patient is a child, please give information pertaining to the insurance policyholder)
NAME OF COMPANY: _____ ADDRESS:_____

OCCUPATION: _____ PHONE: _____

Do we have permission to contact you at your place of employment? _____

If the patient is a child, please provide the following information:

SCHOOL/DISTRICT:_____GRADE:_____

PEDIATRICIAN: _____ PHONE:_____

INSURANCE INFORMATION:

Please be aware that we are not contracted with any insurance company and therefore will not be filing insurance claims for you. Our out of network fees are:
Evaulation: $325.00 Individual Therapy(45mins) $250.00 Group Therapy $100.00

I understand that I am responsible for my bill and authorize payment directly to my doctor.

I authorize this practice and or its agents to act on my behalf to help me secure payment from my insurance companies.

It is my responsibility to inform the office of my current insurance coverage and any change in coverage.

If am not in compliance with my plan procedures I will be responsible for the total balance of my bill.

My current insurance policy is:

Name of Insurance_____ **Id#**_____

Subscribers Name:_____

Subscribers Date of Birth: _____

_____ _____
SIGNATURE OF RESPONSIBLE PARTY **DATE**

FOR OFFICE USE ONLY

DX_____ CLINICIAN _____ FEES_____
Checked_____ Entered_____ Copy of ins card obtained_____ Filing for patient_____

TERMS AND CONDITIONS OF TREATMENT

Financial Responsibilities: Payment is expected at the time that services are rendered. Since we are not contracted with insurance companies, we do not file insurance claims. We will provide you with a monthly receipt that you may submit to your insurance company for reimbursement.

Cancellation Policy: We require 24 hours notice for cancellation of appointments or you will be billed for the missed appointment, unless you have made other arrangements with your clinician.

Phone Calls: Phone calls and messages will generally be returned promptly unless otherwise stated by your clinician. You will be advised as to coverage in case of clinician vacation.

Emergencies: In the event of a clinical emergency and you cannot reach your clinician, you may contact the clinician on call by dialing 973-900-1009. If you do not receive a prompt response, call 911 or go to your nearest emergency room. For all other questions or concerns, contact your individual clinician at his/her direct extension.

Charges and Fees: Please discuss your clinician's fees for services. Please be aware that there may be additional fees for reports, letters, extensive phone contact, conferences with outside providers, school visits, etc.

Billing Questions: Please speak directly to your clinician regarding payment and billing questions. In the event that you need to speak to our billing staff, please leave a message at the front desk. Your phone call will be returned promptly. Please be aware that it takes time to investigate these matters.

Confidentiality: You have the right to privacy and confidentiality with your clinician. We abide by legal and ethical standards to maintain your confidentiality. Exceptions to this standard of privacy occur in the case of imminent risk or danger to oneself or others, child abuse or in the case of legal requirement. Please discuss this matter further with your clinician.

I HAVE READ AND I UNDERSTAND THE POLICIES OUTLINED ABOVE. I AM THE RESPONSIBLE PARTY FOR THE ABOVE NAMED PATIENT AND AGREE TO TREATMENT UNDER THESE CONDITIONS.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY **DATE**

Relationship to Patient (please circle): SELF PARENT OTHER _____