THE PSYCHOLOGY CLINIC, Inc.

Account Number	Therapist	Date of Service

CLIENT	NAME Last	First	MI	Name I prefer to be called	Spouse/Partner Name
ADDRESS Street	City	State	Zip Code		Home Phone Can we call you? **Y/N**
BIRTHDATE	GENDER M F	MARITAL STATUS SING MAR DIV WID SEP			Cell Phone Can we call you? **Y/N**
EMPLOYER Company Name	Address				Work Phone Can we call you? **Y/N**
Emergency Contact	Relationship	Address			Phone Number
Family Physician	Clinic	Address			Phone Number

PARENT OR LEGAL GUARDIAN (if applicable)	Relationship to Client	Birth Date	Home Phone
NAME Last First MI	Address		Cell Phone
EMPLOYER	Address		Work Phone

POLICY HOLDER INSURANCE INFORMATION

PRIMARY INSURANCE	Name of Carrier and Subsidiary Agency	Phone Number	Effective Date
Subscriber / Policy Number	Subscriber Name (Last, First, MI)	Birth Date	Relationship to Client
Group Number			
Subscriber's Address if Different		Group Name / Employer	

SECONDARY INSURANCE	Name of Carrier and Subsidiary Agency	Phone Number	Effective Date
Subscriber / Policy Number	Subscriber Name (Last, First, MI)	Birth Date	Relationship to Client
Group Number			
Subscriber's Address if Different		Group Name / Employer	

(Please Sign and Date other side)

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The fee for the initial consultation is _____. The fee for subsequent sessions is _____ per unit of services provided. Units are based on the amount of professional time utilized. You will be billed for all the time that is reserved for you. If additional time or services (such as telephone contacts) are provided, a pro-rated fee may be charged. There may be a charge if your insurance company, another agency or a third party requires a report. Failure to provide 24 hours advance notice of appointment cancellation or failure to show for an appointment may result in a charge at the regular fee. Repeated late cancellations or no shows may result in your being discharged from the clinic.

If you have insurance, a claim will be filed with your insurance company. Deductibles and/or co-payments are due at the time of your appointment. If a claim filed with your insurance company is disputed, this office cannot accept responsibility for collecting those fees from your insurance company or for negotiating a settlement. Payment of any unpaid portion of the balance will be expected within 30 days after your insurance company notifies The Psychology Clinic, Inc. of the extent of its liability or payment. Arrangements can be made for monthly payments toward your balance.

It is assumed that this financial relationship will continue as long as services are being provided or until such time as the client notifies The Psychology Clinic, Inc. of a wish to terminate treatment. Once treatment terminates, any balance not paid in full will be considered due. If acceptable financial arrangements have not been made, The Psychology Clinic, Inc. reserves the right to utilize legal means to obtain reimbursement. This may result in releasing names and addresses to a collection agency.

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I authorize The Psychology Clinic, Inc. to release any medical information needed to process my insurance claims. I further agree to and authorize payment of any health insurance policy benefits directly to The Psychology Clinic, Inc. I understand that I am financially responsible for services not covered or partially covered by my health insurance. A copy of this authorization shall be as effective and valid as the original.

My signature below indicates that I read, understand and agree to this insurance and fee policy. I will take responsibility for all charges to any account for which I am the designated responsible party.

_____ _____

Client/Legal Representative signature **Date**