

THE CENTER FOR PSYCHOTHERAPY, INC.

At • Essex • Guilford • Old Lyme

Serving the mental health needs of the Shoreline communities
Central Office: 28 Main Street, Essex, CT 06426 • Ph (860) 767-1517 • Fax (860) 767-7703

Patient Information

Date _____ Form Completed By _____ Clinician _____
Name _____ Age _____ Date of Birth _____ Sex _____
Address _____
City: _____ State: _____ Zip: _____
Home Phone _____ Work Phone _____ Social Security # _____
Employer/School & grade _____
In case of emergency, contact: _____
Who referred you to our office? _____
Are you seeing anyone else in our office? Y / N If yes, please list _____
Primary physician _____
Physician's address & phone _____

Patient Billing Information

Bills should be sent to (if other than patient):

Name _____ Relationship To Patient _____
Address _____
City: _____ State: _____ Zip: _____
Home Phone _____ Work Phone _____ Social Security # _____

Primary Insurance Information

Insured's Name _____ Date of Birth _____ Sex _____
Insurance Company _____ Ins. Co. Phone Number _____
Insurance Company Address _____
Patient's Relationship to Insured (Please circle one) Self / Spouse / Child / Other
Insured's Employer _____
Insured's ID # _____ Group or Policy # _____

Secondary Insurance Information

Insured's Name _____ Date of Birth _____ Sex _____
Insurance Company _____ Ins. Co. Phone Number _____
Insurance Company Address _____
Patient's Relationship to Insured (Please circle one) Self / Spouse / Child / Other
Insured's Employer _____
Insured's ID # _____ Group or Policy # _____

For Office Use Only

DSM:

EK MB LS KD MER EH SF

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FINANCIAL AGREEMENT & CONSENT FOR TREATMENT
SIGNATURE ON FILE FORM FOR THE RELEASE
OF INFORMATION AND ASSIGNMENT OF BENEFITS

Patient Name: _____

Date of Birth: _____

If you wish our office to be of service to you in billing your insurance company(ies), we need your signature on the following statement.

Should we not receive this signed authorization, we cannot bill your insurance company(ies) for you and you will have to bill your insurance company(ies) directly.

I authorize **THE CENTER FOR PSYCHOTHERAPY, INC.** to release psychological/medical information pertaining to my examination, history, and medical expenses to my insurance company(ies)* for the purpose of processing insurance claims. This release may include reviewing and/or photocopying pertinent documents for the purposes of payment by my insurance company(ies).

I authorize payment of medical insurance benefits to be made directly to THE CENTER FOR PSYCHOTHERAPY, INC. I permit a copy of this authorization to be used in place of the original.

I understand that my insurance policy may have certain limitations on mental health benefits in the form of precertification, closed provider networks, number of visits allowed or dollar amount per policy year as well as lifetime maximum benefits. I agree to accept full responsibility for charges once these limitations have been reached.

I understand that, other than in an emergency situation, either late cancellation (less than 24 hours notice prior to the appointment time) or a 'no show' to a scheduled appointment will result in my being responsible for the full fee and no insurance benefit will be available. Phone time will be billed to patient directly if in excess of ten minutes' duration. I understand that billing will be separate for each provider I see at THE CENTER FOR PSYCHOTHERAPY, INC.

I understand that unless specific arrangements are made in advance with my provider(s), a delinquent account (over 30 days past due) will result in generating a monthly statement that shall bear interest at the rate of 1.5% per month (18% annual rate) thereafter until paid.

I understand that the undersigned is fully responsible for the bill, despite any previous financial agreement made including, but not limited to, custodial divorce decrees.

I understand that in the event my delinquent account is referred to an attorney for collection, I agree to accept full financial responsibility for payment of all reasonable attorney fees and costs incurred by THE CENTER FOR PSYCHOTHERAPY, INC. in the collection of said account.

I further agree to accept full financial responsibility for payment of charges rendered to the above-named patient.

This form shall be applicable to all providers I may use at THE CENTER FOR PSYCHOTHERAPY, INC.

I authorize THE CENTER FOR PSYCHOTHERAPY, INC. and its employees and agents to release information pertinent to billing and collecting any outstanding balances on my account.

With my signature, I provide my consent to receive treatment at THE CENTER FOR PSYCHOTHERAPY, INC. I understand that, upon request, I will be provided with a written description of patient's rights and of grievance policies and procedures at THE CENTER FOR PSYCHOTHERAPY, INC. *I also understand that all providers at THE CENTER FOR PSYCHOTHERAPY, INC. are mandated reporters of the suspected abuse and neglect of children, the elderly, and persons with disabilities. By my signature I acknowledge that I have been apprised regarding the privacy of my medical record in accordance with the Health Insurance Portability and Accountability Act (HIPAA), a copy of which will be provided at my request.*

SIGNATURE: _____

DATE: _____

IF GUARANTOR, RELATIONSHIP TO PATIENT: _____

*For Medicare Patients this applies to the Social Security Administration or its intermediaries or carriers.