PSYCHOTHERAPY SERVICES ASSOCIATES, LLC

Check one of the following

- ☐ **Alice Berlin, LCSW-C, BCD**
- ☐ **Lawrence Costello, M.D.**
- ☐ **Mary James, M.D.**
- ☐ **Robert Shuman, LCSW-C, CAC**
- ☐ **Stella Hongola, Psy.D.**
- ☐ **Debra Lanouette, CRNP-PMH**
- ☐ **Margaret Stratton, Psy.D**
- ☐ **Roger Sandberg, LCPC**
- ☐ **Alorin Harris, LCSW-C**

PATIENT INFORMATION

Patient's Name _____S.S. # _____

Mailing Address_____ Date of Birth _____

City/State/Zip _____ Marital Status _____

Home # _____ Leave Msg with person or on Machine Yes ☐ No ☐

Cell # _____Msg Yes ☐ No ☐ Work #_____ Msg Yes ☐ No ☐

Email Address (optional)_____Sex: M ☐ F ☐

Name of Primary Care Physician _____ Phone # _____

Primary Insurance _____ ID#_____

Secondary Insurance _____ ID#_____

Policy Holder's Name_____ Date of Birth_____

EMERGENCY INFORMATION

Person to Contact in case of Emergency _____

Relationship to Patient _____ Phone #_____

PRACTICE POLICIES

- You are responsible for insurance company's requirements (ie: referrals, pre-certification and treatment plans, etc.)
- Regardless of what your insurance pays you are ultimately responsible for your bill.
- Payment is expected at the time services are rendered unless specific alternative arrangements have been made with your therapist.
- You <u>will</u> be charged for missed or cancelled appointments if **24 hours notice** is not given.
- **You are responsible to notify us when your insurance coverage changes prior to your appointment**. You will be responsible for payment in the event that information was not received prior to your visit and insurance denies the claim.

FINANCIAL POLICIES

- If your account is outstanding for more than 90 days, the account may be turned over to a collection service and a 25% collection fee may be added.
- Any checks returned to our office are subject to a return fee of $20.00. Immediate remittance in the form of cash, money order, or certified funds is expected.

DISCLOSURES

- I authorize the disclosure of any information necessary for treatment, payment, and healthcare operations.
- ☐ check if you have exceptions about disclosures
- I hereby authorize payment to be made to Psychotherapy Service Associates, LLC for services rendered.

(SEAL) _____ _____

Signature of Patient/Legal Guardian Date