Daniel A. Patz, Psy.D., L.M.H.C.
Licensed Psychologist
Licensed Mental Health Counselor

Francine Odio, Psy.D., L.M.H.C.
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REGISTRATION FORM

Today's date:

Your Name:	Relationship to Client:

CLIENT INFORMATION

Client's Name:	Birth Date:		Age:	
Street address:	SS #		Home #:	
City, State Zip:			Cell #:	
Email Address:				
Client's (Parent's) Occupation:	Client's (Parent's) Employer:		Employer phone #:	
Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other
Other family members seen here:				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #:
Is this person a client here? ❑ Yes ❑ No			

Occupation:	Employer:	Employer address:	Employer phone #:
Is the client covered by insurance? ❑ Yes ❑ No			

Please indicate primary insurance	❑ Amerigroup	❑ United Behavioral Health	❑ Cigna	❑ Aetna	❑ Cenpatico
❑ Ceridian	❑ WellCare	❑ Children's Medical Service	❑ ASO Funds	❑ Other	
Subscriber's name:	Subscriber's ID. #:	Birth date: / /	Group #:	Policy #:	Co-payment: $
Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home # : ( )	Cell# : ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize PATS, LLC or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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INFORMED CONSENT FOR TREATMENT

Client's Name: ___________________________________

Date of Birth: ____________________________________

I, __________________________________hereby give my informed consent to mental health counseling. I understand that this agreement pertains to psychological treatment for mental health issues for which I am requesting these services. By signing this form, I confirm that I have reviewed the Notice of Policies and Practices to Protect the Privacy of Your Health Information form and agree to the content. In addition, by virtue of signature, I give informed consent to receiving said services.

I understand that confidentiality is limited in that, if I express thoughts or plans about hurting myself or others, a law enforcement officer or other appropriate authorities (and/or the person I say I am going to hurt) may be informed. I understand that confidentiality is limited in that, if I report any incidents of physical abuse, sexual abuse, or neglect towards a child, mentally retarded person, or elderly person that a report will be filed with the Department of Children and Families.

In addition, I understand that a minimum 48 hours notice is required if I am unable to keep a scheduled appointment. I will be charged a $50 Missed Appointment fee if cancellation is not made at least 48 hours in advance or if I arrive more than 15 minutes late to my appointment.

__________________________________ __________________

Signature of client ***Date***

__________________________________ __________________

Parent or guardian, if appropriate ***Date***

__________________________________ __________________

Witness ***Date***

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New Client Agreement

We are committed to providing the best quality of care possible. In order to accomplish this, we request your understanding and agreement regarding our policies.

Clients are ultimately responsible for payment of all treatment provided. I hereby assume financial responsibility for the services rendered to me by Psychological Assessment and Treatment Services, LLC including but not limited to: therapy intake; therapy follow-up appointments; case consultation; psychological evaluation including follow-up interviews of myself (and/or my family members) and interviews of other persons as needed; psychological tests; review of documents, records, e-mail, audio & video recordings; conferences with and any written reports to my doctor(s) or attorney or other interested parties.

Services outside of the office - I understand that the fee is $150-$200 per hour for any service that is conducted outside of the office of PATS, LLC. This includes observations, court testimony, depositions, or any other event that takes place outside of the office of PATS, LLC.

A minimum of one (1) hour is charged for out-of-office services. After the first hour, services are billed in 15-minute increments. This fee includes time spent conducting any evaluation and/or psychological tests, review of records, construction of a report or letters, trial preparation for your attorney, and consultations. You will receive an itemized invoice at the conclusion of the service.

Psychological evaluations require a preliminary retainer in order to schedule the evaluation. The retainer is based on the price quoted for the specific type of evaluation. At that time, an estimate of services necessary will be discussed with you in person. Your balance is due at the time of the evaluation and/or when the written report is completed.

Psychotherapy or in-office appointments - I understand that a minimum of 48 hours notice is required if unable to keep a scheduled appointment. **A $50 Missed Appointment fee will be charged for appointments that have not been canceled with at least 48-hour notice**, or if I am more than 15 minutes late to my appointment.

Psychological Evaluation appointments – in or out of offices: We typically schedule 5-6 hours for each client to complete testing. Given that we dedicate this much time to each person, and appointments are usually booked weeks in advance, cancellations or no-shows are quite costly and are unlikely to be rescheduled quickly. We require a **minimum of 48-hour notice for rescheduling or cancellation of a psychological assessment** appointment to allow us time to find someone else to take the appointment. Without such notice, fees will be charged as follows unless alternative arrangements are discussed:

- **Psychological evaluation cancellations (within 48 hours of appointment) OR no-shows (no communication prior to missing the appointment): $250.00**

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NEW CLIENT AGREEMENT CONTINUED

Insurance Denials: While we make every effort to ensure eligibility of insurance prior to your visit, there may be various reasons why insurance may deny reimbursement even after verification by PATS, LLC and yourself. In the event that insurance denies reimbursement for rendered services, the balance is your responsibility. Payments for rendered services that have been denied by your insurance are to be made within 30 days.

Divorce and Child Custody Cases: PATS, LLC will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since PATS, LLC is not a party to these Arrangements, it is not obligated to the financial terms of the Arrangements.

In cases of divorce, the person who receives care at PATS, LLC is responsible for the payment of: copays, coinsurance, deductibles or other feels at time of service.

Regarding child custody, the parent who presents the child (the "Presenting Parent") for care and treatment at PATS, LLC is responsible for the payment of: co-pays, coinsurance, and deductibles at the time of service. This policy applies whether there is joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then PATS, LLC will still collect the applicable co-pays, coinsurance, and deductibles at the time of service from the Presenting Parent.

I understand that I am personally responsible for the charges outstanding on my account. I also understand that the account may be turned over to an attorney or collection agency if I fail to pay all charges within fifteen (15) days after notification that my account is in arrears. If this occurs, I will be responsible for the full fee, interest and all Court costs and attorney's fees.

Assignment of Benefits: I, herby, request that payment of authorized Medicaid or private commercial insurance or any other payer be made on my behalf to **Psychological Assessment and Treatment Services, LLC** for any services furnished to me.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services, and to release all or part of my medical record under whatever means required for payment of my charges be it any insurance carrier(s) or other designee(s).

I also authorize release of information necessary for filing claims to HIPPA compliant medical billing service designated by Psychological Assessment and Treatment Services, LLC.

I understand that my signature below acts as a signature on file. I understand my insurance company may be contacted prior to the delivery of services if precertification is needed to authorize payment of services.

______________________________________	______________________________________
Client (Parent /Guardian) Signature	Client (Parent/Guardian) Printed Name
______________________________________	______________________________________
Witness Signature	Date

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CREDIT/DEBIT CARD AUTHORIZATION

PATS LLC, requires a credit or debit card on file for all services. We will NOT charge this card without your permission, except in the following cases (please check the boxes below to indicate understanding of these circumstances):

❏ Late cancels or appointment no-shows as detailed in the Office Policies and No-show/Late cancel policy
❏ Your bill is more than 90 days past due, without alternative arrangements in place

Please check the box below if you would like us to charge the card automatically for any copayments, co-insurances, or other balances owed on an ongoing basis:

❏ I would like to use this card to pay for ongoing services. Please charge this card below immediately after my appointment(s) for any balance up to $________.

I, ______________________________________ , authorize PATS, LLC to use my credit/debit card information to charge my credit/debit card. I understand that this card will be charged for either late cancellations, no-shows, and past due balances, as outlined in the Office Policies Document.

PLEASE PRINT CLEARLY

Card Type (circle one): Visa MasterCard Discover

Card #: ____________–_____________–_____________–____________ Expiration Date: _________________

Name as Printed on Card: ____

Verification/Security Code (3 or 4 digit code on back of card by signature line): __________________________

Billing Address: ____

City:_____________________________________ State: _______________________ Zip: ___________________

By signing below I am authorizing PATS, LLC *to charge the above card in the designated manner. My signature also indicates that I will inform my clinician of any changes to this billing information over the course of our work together.*

____

Client or Parent Signature Client or Parent Printed Name Date

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Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physicians (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow Psychological Assessment & Treatment Services, LLC (PATS,LLC) to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan and medication if necessary.

Patient Rights

- You may request terminate this authorization at any time by signing a second form indicating you wish to do so; it will not included information that has already been used or disclosed based on your previous authorization.
- You cannot be required to sign this form as a condition of treatment and/or services.
- You have a right to request a copy of this signed authorization to keep in your records.
- You do not have to agree to this request to use of disclose information.

Patient Authorization

□ I authorize the release of any applicable mental health/substance abuse information to my PCP by PATS, LLC.

□ I authorize to release only my medication information to my PCP by PATS, LLC.

PCP Practice Name: ______________________________

PCP Name: ______________________________

Address: ______________________________

Phone: ______________________________

Fax: ______________________________

□ I DO NOT AUTHORIZE the release of any applicable mental health/substance abuse information or medication information to my PCP by PATS, LLC.

□ I do not have a PCP and do not wish to see or confer with one. I therefore DO NOT AUTHORIZE that any of my PHI be disclosed by PATS, LLC.

□ I request to TERMINATE A PREVIOUS AUTHORIZATION. The original authorization was signed on ________________.

I, the undersigned, have read and understand the Patients Rights and have made the decision to give authorization or decline authorization.

______________________ Patient's Name	______________________ Patient's Date of Birth
______________________ Patient/Guardian Signature	______________________ Date
______________________ Witness Signature	______________________ Date nothing

PATS
PSYCHOLOGICAL ASSESSMENT
&
TREATMENT SERVICES, LLC
FOSTERING CHANGE, FOSTERING GROWTH

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ACKNOWLEDGEMENTS

My initials and signatures below, indicate that I acknowledge I have been provided with written information for review or to keep regarding the following policies and procedures of Psychological Assessment and treatment services.

Please Initial that you have read and understand each below:

_______ I acknowledge that I have been given information about the use and disclosure of my protected health information (PHI) (HIPAA)

________I acknowledge that I have been given the Financial Responsibility agreement

________I acknowledge that I have been given the Debit/Credit Card Authorization form.

________I acknowledge that I understand the Missed Appointment policy

I understand that my signature below acts as a signature-on-file in acknowledgement that I have read, reviewed, or received the forgoing policies and procedures of PATS, LLC.

________________________________ ________________
Signature of Client or Parent/Guardian **Date**

________________________________ ________________
Client **Date**

________________________________ ________________
Witness **Date**

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