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PATIENT INFORMATION

Patient Name: _____ **Marital Status:** ____ **Today's Date** __/__/__
Current Address: _____ **Gender: (M) (F)** **Date of Birth:** __/__/__
City, State, Zip: _____ **Social Security #** _____
Home Phone: _____ **Work Phone:** _____ **Mobile #:** _____
Employer's Name: _____ **Occupation:** _____
Employer's Address: _____ **E-mail Address:** _____
Family Physician: _____ **Referred by:** _____
In case of emergency, notify: _____

Area Code and Telephone # _____ Relationship _____

INSURANCE INFORMATION

If you'd like me to file with your insurance company, I will also need to make a copy of your insurance card.

Policy Holder's Name: _____ **Policy Holder's SS#:** _____
Policy Holder's ID#: _____ **Policy Holder's Group #:** _____ **Policy Holder's Date of Birth:** __/__/__
Effective Date of Coverage: __/__/__ **Policy Holder's Employer:** _____
Employer's Phone: _____ **Insurance Company's Claim Phone:** _____
Policy Holder's Current Address, if different from above: _____
Policy Holder's Home Phone: _____ **Policy Holder's Gender: (M)(F)** **Policy Holder's Marital Status:** _____
Relationship to Patient: _____

Insured's Signature

Insurance Company's Billing Address: _____

Please tell me where you got my name? (If from the Yellow Pages, was it from Psychotherapists or Marriage and Family?) _____

PLEASE CHECK TO BE SURE YOU HAVE FILLED THIS FORM OUT AS COMPLETELY AS YOU ARE ABLE

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE, SUCH AS INSURANCE REIMBURSEMENT. ALL OF THE INFORMATION YOU DISCLOSE IS PROTECTED. YOU AUTHORIZE ANY AND ALL WAYS IT IS USED OR DISCLOSED.

_____ **Check here if this authorization is for psychotherapy notes.**

If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected health information.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Individual Patient's Name: _____

Street Address: _____

City/State/Zip: _____

Telephone #: Home: _____ Mobile: _____ Work: _____

E-Mail Address: _____ Social Security Number: _____

2. SPECIFIC USE AND/OR DISCLOSURE I AM AUTHORIZING

Describe in detail the protected health information you are authorizing to be used and/or disclosed, for example, dates of sessions, diagnosis. If this authorization is for psychotherapy notes, no other type of protected health information may be listed here:

Name the people and/or organization (or kinds of people and/or organizations) that you are authorizing to use and/or disclose the protected health information above.
Seyma Calihman, LCSW

Name the people and/or organizations (such as your insurance company or another health professional) that you are authorizing to receive and use your protected health information.

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed, such as insurance reimbursement or consultation.

3. ENDING THIS AUTHORIZATION:

Select one of the following choices:

____ This authorization will end on the following date: _____

____ This authorization will end when insurance reimbursement is complete

____ This authorization will end when the following event happens. The event must relate to the individual or purpose of the authorized use and/or disclosure. Describe the event below.

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION:

I understand that I may revoke this authorization at any time by giving written notice to Seyma Calihman, LCSW, but not for any actions taken before my written revocation notice. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT:

I understand that under most circumstances a healthcare provider may not refuse treatment if I choose not to sign this authorization. However, I understand that my insurance company may condition my enrollment in my health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. INDIVIDUAL PATIENT'S SIGNATURE:

I have had a chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ **Date:** _____

If this authorization form is signed by a personal representative for the client:

Personal Representative's Name: _____
Print Name

Signature

Relationship to the Individual patient:

YOU HAVE A RIGHT TO A COPY OF THIS FORM AFTER YOU SIGN IT

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OFFICE POLICY REGARDING INSURANCE AND PAYMENT

Payment: Payment-in full is due at the time of service if you are not utilizing health insurance.

Insurance: If I am a Preferred Provider for your plan, you are responsible for a co-pay, and the insurance company pays the remainder of your fee. There is usually no deductible. If I am not a Preferred Provider and you have a PPO plan that reimburses for mental health services, your insurance company will still pay part of your fee once you have met your deductible. I will file for you if you wish, but we won't know your portion of the fee until I receive reimbursement. I will need payment-in-full until we know what the reimbursement will be. I will refund or credit you if I am overpaid.

➔ TWO IMPORTANT THINGS TO BE AWARE OF:

1. Some plans require preauthorization. The only way to know for sure is to call your insurance company or consult your manual before you begin therapy. You are responsible for making the phone call for preauthorization. You are responsible for payment if reimbursement is refused because this requirement was not met by you.
2. If you have a deductible, you are responsible for paying it. Insurance companies do not reimburse until the deductible is paid.

You should understand the rules for your particular policy (deductible, co-pay, need for preauthorization, number of sessions, etc.). In case you are unable to call them and get this information before the first session, I will need payment-in-full (\$125) until I know the details of your policy.

Ultimately, you are responsible for paying for the services you receive. If your insurance company refuses to pay a claim for a service you request and I provide it, it is your responsibility to pay for the service.

Missed Appointments: I understand that from time-to-time you may need to cancel an appointment. Please notify me at least 24 hours beforehand so another client may have access to that time. If you cancel a session less than 24 hours ahead of time, the entire fee (\$125) will be billed to you (since your insurance company will not reimburse for missed sessions), as will all appointments missed without notification.

Fee: I understand that the fee is \$125 per 50-minute session, and (if applicable) my co-pay is _____ per session. Longer sessions will be charged at a prorated fee. I accept checks and cash.

I have read and understand the above: _____
Signature

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PRIVACY POLICY ACKNOWLEDGEMENT

I have reviewed a copy of "**PROTECTING YOUR PRIVACY**".

Name _____ Birth Date _____

Signature _____ Date _____