CLINICIAN'S NAME____
225 S. MERAMEC, #506 * CLAYTON, MISSOURI 63105 * 314/896-3588
PLEASE PRINT CLEARLY

NAME____DOB____

FULL ADDRESS__________________________________CITY____

STATE__________ZIP____________________TODAY'S DATE______________________MALE OR FEMALE

HOME #____CELL #____

WORK #_______________ _______EXT: ________________ EMAIL____ _____

SSN#____MARITAL STATUS____________________________________

EMPLOYER_______________________________________OCCUPATION____

EMPLOYER ADDRESS____

PARENT/SPOUSE'S NAME___________________________SSN#____

PARENT/SPOUSE'S EMPLOYER______________________WORK #____

EMPLOYER ADDRESS_____________________________OCCUPATION____

INSURANCE NAME_______________________________PLEASE PRESENT CARD FOR COPYING___________________

EAP____PROVIDER____

HAVE YOU CALLED FOR AUTHORIZATION IF NECESSARY? YES NO AUTH

#_____________________________

REFFERED BY____

DO YOU HAVE A SECONDARY INSURANCE? YES NO

NAME/NUMBER OF SECONDARY____

NAME OF PRIMARY CARE DOCTOR_______________________NAME OF PSYCHIATRIST IF ANY___________________

THEIR ADDRESS AND PHONE #_______________________________/____

CURRENT MEDICATIONS____

PLEASE READ CAREFULLY BEFORE SIGNING

ALL PAYMENTS AND CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. A 24 HOUR APPOINTMENT CANCELLATION NOTICE IS REQUIRED TO AVOID A FULL CHARGE BEING MADE TO YOU.

PLEASE SIGN HERE TO SHOW THAT YOU HAVE READ THE ABOVE____

- I GIVE MY PERMISSION FOR MY CLINICIAN TO FILE MY INSURANCE CLAIMS ON MY BEHALF.
- I AUTHORIZE THE RELEASE OF MY DIAGNOSIS (OR OTHER MEDICAL INFORMATION NECESSARY) TO PROCESS MY CLAIM TO MY CARRIER AND IT'S ENTITIES.
- I AM CONSENTING TO THE ASSIGNMENT OF BENEFITS BE MADE TO MY CLINICIAN.
- IN THE EVENT MY INSURANCE FAILS TO REIMBURSE MY CLINICIAN, I AM FINANCIALLY RESPONSIBLE FOR THE UNPAID BALANCE.

PLEASE SIGN HERE TO SHOW THAT YOU HAVE READ THE ABOVE____

SHOULD YOUR INSURANCE CARRIER DO RANDOM SITE REVIEWS, THEY CAN ONLY VIEW YOUR CHART. THEY CANNOT COPY, REMOVE, OR DISCUSS YOU FILE WITHOUT A SEPARATE SIGNED RELEASE FROM YOU. HOWEVER, YOUR SIGNATURE IS REQUIRED IN ORDER FOR YOU CLINICIAN TO EXCHANGE DATA WITH THE PRIMARY CARE M.D. NAMED ABOVE WHILE USING THIS INSURANCE AND THIS CLINICIAN

PLEASE SIGN HERE____

PHOENIX PSYCHOLOGICAL GROUP, INC.

STATEMENT OF FINANCIAL AGREEMENT
CONSENT TO TREATMENT

Please read the following carefully before signing below where indicated……………………

I have chosen tO receive psychotherapy services through Phoenix Psychological Group, Inc. My choice is voluntary and I understand that I may terminate at any time by letting my therapist know my intention to terminate.

CONFIDENTIALTIY POLICY

All therapeutic communication, records, and contacts with professional and support staff will be held in strict confidence. Information may be released, in accordance with state law, only……………

1. When the client signs a written “Release of Information” indicating informed consent.
2. When the client elects to use insurance, managed care organizations, or other third party payers.
3. When the client expresses serious intent to harm himself/herself or someone else.
4. When there is evidence or reasonable suspicion of abuse against a child, dependent adult, or elderly adult.
5. When a subpoena or other court order is received directing the disclosure of information.

Regretfully, we cannot maintain desire confidentiality where the client elects to use insurance or other third party payers. Confidentiality is not respected in most cases of managed care. Clients who choose to use insurance and managed care programs agree that they will not hold **Phoenix Psychological Group, Inc.** or its staff liable for any and all disclosures and consequences of confidential records information demanded by and released to third and fourth party payers. Clients who want strict confidence would consider alternate ways to pay for services. We realize that all information may not be pertinent to each insurance company, we will use the utmost discretion.

INSURANCE

By signing below, you are agreeing to be held responsible for any and all denied charges, co-pays, deductibles, over the limit fees, or exhausted benefit balances. You are signing that you understand that if your insurance company. Or other agent, should fail to pay benefits to **Phoenix Psychological Group, Inc**., and you are electing to continue in you therapy, that you will be financially responsible of any unpaid balance. You may utilize a mutual payment arrangement with the office should this occur. As a parent or guardian of a patient, you are agreeing to be financially responsible for any d balance by the above outlined.

You have the right to know what to expect from your insurance carrier. Since coverage for mental health services is usually very different from coverage for other health needs, we urge you to gather as much information before your appointment (I.e. referrals, authorizations, number of visits allowed by your plan, the deductible, what the co-pay is, etc.) failure to have this information results in more out of pocket expenses for you as **Phoenix Psychological Group Inc**. is not responsible to keep you abreast of each individual plans boundaries, we are limited only to our contractual accountability predetermined by that carrier. Payment for our services rendered is the obligation of the undersigned irrespective of any insurance but we will certainly work with you to gain every financial benefit you are entitled to for **Phoenix Psychological Group, Inc.**

I, the undersigned, certify I (or my dependent) have insurance coverage with _______________________. And sign directly to Dr. Patricia Shaw all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges regardless of insurance status as

well as any associated costs for collections should such action become necessary. I agree that authorization shall be valid until rescinded in writing or replace by one of a later date. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

CANCELLATION POLICY

A strict cancellation policy is enforced for our office. We ask for a "**24 hour notice**" to cancel your appointment to avoid a full charge of $100.00 being made to your account. Late cancels and "no shows" cannot be billed to any insurance carried and are therefore the sole responsibility of the client. We do realize emergencies happen and we will adjudicate each case on it's own circumstances.

My signature below indicates that I have read the above statements and agree to abide by the outlined information therein.

CLIENT SIGNATURE_______________________________________DATE________________

PRINT NAME____

WITNESSED____

PATIENTS NAME IF MINOR_________________________________DATE_________________