Psychological Services of Charlotte

CHILD

Client Registration Information

Name:_____ Today's Date:_____
(Last,) (First,) (Middle Initial)
Parent's Name:
Mom:_____
Dad:_____
Step Mom (s):_____
Step Dad (s):_____

Age:_____Sex:_____Race:_____ Date of Birth:_____
Social Security Number:_____

Current Address:_____ Phone Numbers:Home:_____
Cell: _____
_____ Work:_____ (City)
(State) (Zip) Email:_____

Grade Level:_____ School Attending:_____
Progress/Problems In School:_____
_____

How were you referred to this office?_____
Primary Care Physician:_____Psychiatrist:_____
Emergency Contact:_____Phone#:_____
Address:_____

Insurance Information

Parent Place of Employment:_____
Parent/Policy Holder Social Security Number:_____
Parent Date of Birth:_____

I. Primary Insurance Company_____Phone#:_____
Mailing/Claims Address_____Group#:_____
_____Policy #:_____
Policy Holder:_____Self_____Other:_____Relation to Client:_____
Authorization Number:_____
Policy Holder Social Security:_____Date of Birth:_____
II. Secondary Insurance Company_____Phone#:_____
Mailing/Claims Address_____Group#:_____
_____Policy#:_____
Policy Holder:_____Self_____Other:_____Relation to Client:_____
Authorization Number:_____
Policy Holder Social Security:_____Date of Birth:_____

Informed Consent for Treatment

I give my consent for the staff of Psychological Services of Charlotte to provide a mental health evaluation and appropriate treatment to myself. This consent covers the treatment by my therapist, psychologist or psychiatrist.

Client/ Legal Guardian Initial: _____

Consent for Treatment of Medical and Psychiatric Emergencies

I give my consent for this office to initiate first aide measures, to contact my Primary Care Physician, or alert the emergency medical system. I also consent for my emergency contact to be notified.

Client/ Legal Guardian Initial: _____

Psychological Assessment Fee for Service Agreement

If psychological testing is recommended and agreed upon, I fully understand the psychological assessment is provided at a Fee For Service rate of $180 per hour and $200 per hour for personality tests. By accepting this agreement, I agree that **neither PSC nor I will bill** the insurance/managed care company for the payment of these services.

Client/ Legal Guardian Initial: _____

Missed Appointment

Psychological Services of Charlotte requests that in the event you are not able to make an appointment for whatever reason, that you cancel the appointment with 24 hours prior to that appointment to maximize appointment times for all other clients. Please be aware that failure to do so will result in a $75 fee that is not reimbursable by any insurance company and therefore is your direct responsibility.

Client/ Legal Guardian Initial: _____

Returned Checks

A check returned for insufficient funds will convert into an **electronic transaction** through the Automated Clearing House (ACH) network. Your account will be debited for the face amount of the check plus the returned check fee of $25. A limit of 2 occurrences applies prior to checks no longer being accepted at PSC for payment.

Client/

Legal Guardian Initial: _____

****I have read, understand, and agree to all of the above information****

Client/Legal Guardian Signature:_____ **Date:**_____

Psychological Services of Charlotte, Inc.
1923 J.N. Pease Place, Suite 204
Charlotte, NC 28262
Office (704) 503-3535
Fax (704) 593-5555

Financial Policy/Agreement

- Information we receive from your insurance company is strictly an estimate of benefit and not a guarantee of payment. Your co-pay, deductible, and/or cost share amounts, as well as any non-covered services from your visit, are due at the time of service. I understand that I am ultimately financially responsible for all charges and fees related to the treatment rendered to me at Psychological Services of Charlotte.
- I understand that the filing of any medical insurance claims is a courtesy Psychological Services of Charlotte extends for convenience, and I am ultimately responsible for the charges and authorizations with my insurance company.
- I authorize payment of medical benefits to Psychological Services of Charlotte for services rendered.
- If I feel that my claim has been inaccurately denied for something other than error on Psychological Services of Charlotte's behalf, it is my responsibility to dispute this directly with my insurance provider. I will be responsible for any remaining balance on my account at that time. If the claim is later resolved by my insurance provider, Psychological Services of Charlotte will refund any amount due.
- I am responsible for obtaining a referral/authorization if my insurance provider requires a referral/authorization in order to be seen in the office. Referrals/authorizations not obtained within 5 business days prior to the visit will require the full amount of the visit to be paid in full at that time.
- Psychological Services of Charlotte requests that in the event you are not able to make an appointment for whatever reason, that you **cancel the appointment with 24 hours prior to that appointment** to maximize appointment times for all other clients. Please be aware that failure to do so will result in a $75 fee that is not reimbursable by any insurance company and therefore is your direct responsibility.
- If new insurance is presented at the time of the appointment and takes longer than 15 minutes to verify, I will be given the option of paying for services in full or rescheduling the appointment. If insurance benefits are verified once I have been seen and payment has been made, Psychological Services of Charlotte will file the claim and reimburse the remaining difference.
- I understand that not all insurance companies coordinate benefits with one another. It is my responsibility to let staff know when checking in for my appointment in order for benefits to be applied to that visit.
- If payment from my insurance provider has not been received within 60 days from the initial filing date of claim, it is my responsibility to pay my account balance in full.
- I authorize the release of any medical information necessary to process claims for services rendered.
- It is our office's policy to send accounts over 120 days to the collection agency of our choice.
- I understand that if my account is assigned to an attorney for collection and/or suit, Psychological Services of Charlotte shall be entitled to reasonable attorney's fees and costs for collection, and that information regarding my account may be released.

****I have read, understand, and agree to all of the above information****

Client/Legal Guardian Signature: _____ Date: _____

Method of Payment

Psychological Services of Charlotte will **ONLY** accept cash, Visa, American Express, Discover, MasterCard, Personal Checks, or Money Orders.

Personal Information

Please take a moment to help us better understand your situation by filling out these questions. *Please know that this information will be highly respected as part of your protected health information, and will be a part of your **confidential** file.* We thank you for choosing Psychological Services of Charlotte, and we trust we may be able to meet your psychological needs.

Reason to today's visit:_____

_____

Do you see yourself/your child as struggling with:_____Depression _____Anxiety
_____Anger _____Family

Problems: _____Substance Use Problems
_____Other:_____

Who do you/your child live with:_____

Any major medical problems:_____

Current Medications/Doses: 1)_____2)_____

3)_____4)_____

Have you/your child experienced therapy before:_____Never
_____Yes: How many Therapists:_____

Have you/your child been admitted to a hospital for psychiatric reasons:
_____Never
_____Yes, how many times:_____

What are your main goals for therapy:

1)_____

2)_____

3)_____

****Thank you for your time, effort and patience with all this needed paperwork. Your doctor/therapist will be with you shortly.****

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of Psychological Services of Charlotte, Inc. Notice of Privacy Practices.

_____ or _____
Print Name Print Guardian Name

_____ _____
Signature Date signed/received

_____

_____

The following is for PSC Internal use only

PSC attempted to obtain acknowledgment of receipt of Notice of Privacy Practices. Acknowledgement could not be obtained as specified below:

_____ Individual refused to sign

_____ An emergency situation prevented obtaining the acknowledgment. The Notice of Privacy Practices will be provided an acknowledgement obtained as soon as it is reasonable practicable to do so.

_____ Other (Please Specify) _____

_____

_____ Individual agreed for PSC to mail a copy of the Notice of Privacy Practices. Record date, address and to who the Notice was mailed:

_____

_____

STAFF SIGNATURE:_____ DATE:_____