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PSY17044

(FILL OUT COMPLETELY-IF INCOMPLETE CLAIMS WILL NOT PROCESS AND INSURED WILL BE RESPONSIBLE FOR CHARGES)

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Social Security Number: _____ Sex: M ___ F ___ Marital Status: _____

Home Address: _____ City: _____ Zip: _____

Home Ph: () _____ Cell Phone: () _____

Employer Name: _____ Work Number: _____

INSURANCE INFORMATION (ATTACH COPY OF INSURANCE CARD FRONT AND BACK)

Primary Insurance: _____ Type of plan: _____

Insurance Address: _____ City/State/Zip: _____

Insured Name: _____ Relation to patient: _____

Insured Date of Birth: _____ Insured Social Security Number: _____

ID#: _____ Group #: _____ Effective Date: _____

Insurance Phone #: _____ Employer: _____

Primary Insurance: _____ Type of plan: _____

Insurance Address: _____ City/State/Zip: _____

Insured Name: _____ Relation to patient: _____

Insured Date of Birth: _____ Insured Social Security Number: _____

ID#: _____ Group #: _____ Effective Date: _____

Insurance Phone #: _____ Employer: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ insurance company (ies) and assign directly to _____ all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether paid by the insurance or not. I hereby authorize the doctor/clinician to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP

DATE SIGNED

CANCELLATIONS: Appointments are regarded as contract for the exclusive use of the doctor's time. I understand that regular charges may be applied to missed appointments without 24 hours advance cancellation notice. I understand that my insurance carrier will not pay for my absence and I will be responsible for these charges.

Note: Please contact C.D. Billing Services for all billing and payment questions.

Telephone # (650) 344-6961 Fax # (650) 344-6604

PATIENT FINANCIAL AGREEMENT

CONFIDENTIALITY:

I understand that my records are confidential and will not be released to outside individuals of agencies without written consent. However certain information may be released without my authorization under the following circumstances:

1. In the event of a medical emergency.
2. If there is evidence of child abuse, dependent or elder abuse.
3. When a hazard to the public requires disclosure.
4. When there is an indication that I will likely harm myself.

TELEPHONE CONSULTATIONS:

I understand that telephone consultations are not covered by Medicare and other health plans. Therefore, I understand that telephone contacts beyond appointment scheduling may result in a charge equivalent of \$120.00 per hour for the duration of call.

CANCELLATIONS:

Appointments are regarded as a contract for the exclusive use of the doctor's time. I understand that regular charges may be applied to missed appointments without 24 hour advance cancellation notice. I understand that my insurance carrier will not pay for my absence and I may be responsible for these charges.

Signature: _____ Date: _____
(I understand my financial and business agreements listed)

PAYMENT OPTION:

I AUTHORIZE MY CREDIT CARD TO BE BILLED FOR ANY AND ALL OUT-OF-POCKET CHARGES THAT MAY BE INCURRED.

VISA / MASTERCARD (circle one) Card # _____ EXPIRATION: _____

SIGNATURE: _____ DATE: _____