

Jerry Post, Psy.D., PC

Identifying Information

Patient's name: _____ Date: _____

*Preferred phone: _____ Alternate phone: _____

*We will use this number for routine matters, such as schedule changes, reminder calls, etc.

Consent for Treatment

(check YES or NO for each)

YES

NO

I have received, read and understand the *Disclosure Statement and Services Agreement* provided to me.

I have received, read and understand the *Privacy Notice* provided to me.

I have received, read and understand the *Limits of Confidentiality* provided to me.

I authorize the release of necessary information to the agency referring me to **Jerry Post, Psy.D., PC**.

I authorize the sharing of relevant information among **Jerry Post, Psy.D., PC** clinicians and support personnel.

I agree that services with **Jerry Post, Psy.D., PC** may be terminated if I am untruthful about medication use, am currently misusing medications, and/or am actively accessing multiple medical providers/prescribers for prescription services.

Signature of Patient: _____

Payment Agreement

(check YES or NO for each)

Patient's name: _____

YES

NO

I understand the fee for the initial session is \$180.00, and subsequent sessions are generally \$110.00 per 45-50 minute session. Fees for services are available upon request.

I understand that **Jerry Post, Psy.D., PC** may file claims on my behalf and will accept third party payments on my account, but that I am responsible for payment of any unpaid balances on my account, subject to the terms of any agreement **Jerry Post, Psy.D., PC** may have with my insurance provider.

I authorize the release of necessary information to process insurance or collection claims, and I authorize payment of claims directly to **Jerry Post, Psy.D., PC**. I give **Jerry Post, Psy.D., PC** permission to submit my name and account information to a third party for collection of past due amounts for which I am responsible.

I agree to pay fees: in full at time of service full co-pay at time of service

Other arrangements: _____

Signature of Responsible Party: _____

How were you referred? _____

NEW PATIENT INTAKE

Patient's Name _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN #: _____

PRIMARY INSURANCE

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

Guarantor Name: _____ Guarantor's DOB: _____

Relationship to patient: _____

SECONDARY INSURANCE

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

Guarantor Name: _____ Guarantor's DOB: _____

Relationship to patient: _____

TERTIARY INSURANCE

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

Guarantor Name: _____ Guarantor's DOB: _____

Relationship to patient: _____

*****This sheet must be filled out in its entirety for insurance to be billed.**

Thank you