Linda Berlin, Psy.D.

&

Psychological Associates, P.A.

ORIENTATION INFORMATION

Welcome to Linda Berlin, Psy.D. & Psychological Associates, P.A. In addition to completing the forms in this packet, we are required by law to provide you with a Notice of Privacy Practices. You may also find a copy of our Notice of Privacy Practices posted in our waiting room, on our website at www.berlinmentalhealth.com, or by requesting a copy from one of our office staff or your therapist.

DATE _____

PLEASE PRINT CLEARLY

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH _____ SEX _____

PATIENT'S SS# _____ REFERRED BY _____ PATIENT'S OCCUPATION _____

PATIENT'S ADDRESS: _____

CITY _____ STATE _____ ZIP _____ MARITAL STATUS _____

TELEPHONE: H: _____ W:_____ C: _____

PERSON TO CONTACT IN AN EMERGENCY _____ PHONE _____

INSURED'S NAME: _____ INSURED'S SS#_____ INSURED'S BIRTHDATE _____

RESPONSIBLE PARTY INFORMATION

Only fill out this section if the patient is a minor or someone other than the patient is responsible for payment. If someone other than the patient is responsible for payment of services, a Financial Agreement MUST be signed by the Responsible Party.

RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

HOME ADDRESS OF RESPONSIBLE PARTY _____

CITY _____ STATE _____ ZIP _____ MARITAL STATUS _____

RESPONSIBLE PARTY'S TELEPHONE: H: _____ W: _____ C: _____

SS#: _____ RESPONSIBLE PARTY'S EMPLOYER _____

HOW MAY WE CONTACT YOU?

What telephone numbers may we call to confirm appointments?

PATIENT:	H	W	C	Do Not Confirm	(Circle all that apply)
RESPONSIBLE PARTY:	H	W	C	Do Not Confirm	(Circle all that apply)

Should correspondence be sent to the patient's address or the responsible party's address?

(Circle One) Patient Responsible Party Neither

If you answered "Neither," please provide us with an alternate address in which to send correspondence.

_____

By signing below you agree that we may contact you in the manner indicated above.

Signature: _____

ASSIGNMENT OF INSURANCE BENEFITS

Please remember that insurance is considered a method of reimbursing the providers. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

This office requests an assignment of benefits for our files, should your account become delinquent, requiring this office to receive the insurance reimbursement.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including private insurance, and other health plans to: LINDA BERLIN, PSY.D. & PSYCHOLOGICAL ASSOCIATES, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Name: _____ Signature: _____ Date: _____

FINANCIAL AGREEMENT

This is a Financial Agreement between _____ hereinafter known as "I", "You", "Your" or "My" AND **Linda Berlin, Psy.D. & Psychological Associates, P.A.**, hereinafter known as the "Practice", "We" or "Us". As an independent contractor of the Practice, your clinician has entered into a separate agreement with the Practice in which your clinician has assigned the collection of his/her fees to the Practice.

Your financial obligation depends on whether you are using managed health care (such as an HMO or PPO) or whether you are choosing not to use insurance or you have an insurance plan which pays a percentage of the total charge (such as 80/20 split plans).

□ Your therapist has agreed to provide counseling and/or psychotherapy to you at the rate of $_____ per session. (Self pay individuals and 80/20 split or similar indemnity insurance plan).

OR

□ If you are using managed care, your therapist has entered into a contract with your managed care company to provide services at a specific rate which requires you to pay a copay of $_____ per session***. (For individuals using Managed Care such as HMO's and PPO's).

*** The copay amount indicated above is our good faith belief based upon information obtained by us from your insurance company. However, it is possible that after submitting your insurance claim, it is determined by your insurance company that your insurance policy requires a copay of an amount different from that stated above. Please be aware that should your copay be greater than that stated above, you will be responsible for the additional funds due.

Please initial EACH line acknowledging your agreement to and acceptance of the following additional terms of this Agreement.

_____ I understand and agree that I am directly responsible to the Practice for all bills submitted to me for services rendered by the patient's clinician.

_____ I understand that payment for each session is due prior to obtaining services and agree to pay the above-stated amount due prior to each session.

_____ **24 HOUR LATE CANCELLATION/NO SHOW POLICY:** I understand and agree that I will be charged my copay and all additional money that my insurance has contracted with my clinician for the services provided for the missed visit **(e.g: Contracted Rate =$90 Your payment for missed visit will be $90 which <u>includes</u> your co-pay)**

If you are using insurance, you must initial these statements as well. If you are not using insurance, you may skip this section.

_____ I understand and agree that although the Practice will contact my insurance company in order to obtain benefits, the Benefits5244 information given to the Practice may be different than what my insurance company actually pays. (ie., when we call to obtain your insurance policy benefits, we may be told that your copay is only $15; but after submitting your claim, we learn that your copay was actually $25, you will be responsible for the additional $10 dollars that you are required to pay by your insurance company).

_____ Therefore, I agree that I am ultimately responsible for confirming the copay amount per visit from my insurance company prior to services being rendered and should I or the Practice be misinformed by my insurance company as to the amount of my copay, I will be responsible for any additional funds due to the Practice.

_____ I understand that if my insurance company requires Pre-Authorization prior to being seen by my clinician, I will make the necessary arrangements to obtain Authorization prior to being seen by my clinician.

_____ I further agree that if I fail to obtain this Pre-Authorization or change insurance companies after obtaining Pre-Authorization without informing the Practice prior to services being rendered, I will be responsible for the ***full*** contracted rate agreed on between my clinician and my prior insurance company which authorized the services rendered.

_____ I agree to pay any deductible amount, co-insurance, or any other balance not paid by my insurance company.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of Collection. By signing below, you acknowledge your understanding and acceptance of the terms of this agreement.

_____ _____ _____

Name of Responsible Party Signature of Responsible Party Date

_____ _____

Social Security Number of Responsible Party Patient Name