

**Comprehensive Psychological Services**  
**(PLEASE PRINT)**

***Patient Information***

Patient Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Marital Status:  Single  Married  Divorced  Widowed  Separated  Gay  
Social Security #: \_\_\_\_\_ Gender:  M  F Date of Birth: \_\_\_\_\_  
Phone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Please circle where CPS may leave messages to confirm appointments – HOME WORK CELL  
E-mail Address: \_\_\_\_\_  
Name of Spouse or (if patient is a child) Parent(s): \_\_\_\_\_  
Patient's Home/Mailing Address: Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Patient Employed by \_\_\_\_\_ Position: \_\_\_\_\_  
In case of emergency, who should we notify? \_\_\_\_\_ Phone: \_\_\_\_\_  
Address of emergency contact: \_\_\_\_\_  
Name of person or company who referred you to us: \_\_\_\_\_

***Primary Insurance***

Insurance Company: \_\_\_\_\_ Copay Amount? \_\_\_\_\_  
Insurance Company Claims Address: \_\_\_\_\_  
Insurance Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  M  F  
Address (if different from patient's): \_\_\_\_\_  
Phone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Subscriber Employed By: \_\_\_\_\_ Position: \_\_\_\_\_

***Additional Insurance***

Is the patient covered by additional insurance?  Yes  No ***If no, skip this section.***  
Insurance Company: \_\_\_\_\_  
Insurance Company Claims Address: \_\_\_\_\_  
Insurance Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  M  F  
Address (if different from patient's): \_\_\_\_\_  
Phone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Subscriber Employed By: \_\_\_\_\_ Position: \_\_\_\_\_

***Authorization & Referral Information***

Does your insurance require a referral or pre-authorization **PRIOR** to your first visit?  Yes  No  
Authorization #: \_\_\_\_\_ # of Sessions Authorized: \_\_\_\_\_

***\*\*It is YOUR responsibility to check with your insurance regarding pre-authorization BEFORE your appointment begins. If your insurance does not pay because you did not obtain pre-authorization, you will be responsible for the full amount due.\*\****

**PLEASE READ AND SIGN THE BACK OF THIS FORM.**

For Office Use:

**Comprehensive Psychological Services**  
**PROFESSIONAL SERVICE AGREEMENT**

Please initial in the spaces provided and sign the bottom.

***Fees, Payment, and Insurance Billing***

\_\_\_ I agree to make payment before my appointment begins. I agree to pay my **known copay**, 1/2 of the fee (if my insurance pays a percentage), or the full fee (if I am a cash pay client) at the time of service. If I do not have this payment at the time of service, I will be charged a \$10 service fee to have the payment billed to me.

\_\_\_ I understand that **appointments not canceled 24 hours in advance will result in a charge**. This fee is \$25 for a counseling session, and \$40 for a medication management session. (This cannot be billed to your insurance.) Additional fees may be billed for services such as phone calls more than 10 minutes in length, written reports, and other professional services. CPS *may* provide courtesy reminder calls, but it is **not guaranteed**. Patients may not dispute a fee (as explained above) based upon not receiving a reminder call.

***Finance Charges***

\_\_\_ In the event that my account is not paid as agreed or I am delinquent, I agree to pay a collection fee of 30% of my unpaid balance in addition to my balance. In the event that it is necessary to commence legal action to collect this bill, I agree to pay reasonable attorney's fees and costs of court and to submit to the jurisdiction of Comprehensive Psychological Services, Inc. If any portion of this bill or the provider's services is disputed, I agree to submit myself to mediation or arbitration and will pay the cost in doing so.

***Authorization***

\_\_\_ I authorize the release of any medical, psychiatric, and/or alcohol or substance abuse information necessary to process fee for service claims to my insurer. I authorize payment of insurance benefits to Comprehensive Psychological Services or any facility authorized by Comprehensive Psychological Services. By signing this form, I am requesting that Comprehensive Psychological Services open an account in my name. My insurance or my employer may offset the expense I incur. If not, I accept the financial responsibility to settle whatever balance is generated when payment is not received following 60 days from the billing date.

***Consent for Treatment***

\_\_\_ Most people benefit by participating in psychological services; however, there is no guarantee that you or your family members will be helped. In signing for services for a minor, I certify that I am the legal guardian and I have the legal right to approve of the evaluation, treatment, and release of information. I understand that my therapist will keep all information about me confidential unless I give my written consent through a release of information. My therapist is, however, required by law to report clear and present danger to human life or any form of child abuse. I also understand that it may be necessary to furnish information to a court of law if a subpoena is issued (in cases of child custody, accidents, or divorce).

***Privacy Practices & Consumer Rights***

\_\_\_ I acknowledge that I have received a copy of Comprehensive Psychological Services Privacy Practices and Consumer Rights Policy & Procedures.

***Emergencies***

Please inform the person answering the phone if you are in a crisis situation. If your therapist is unavailable, another therapist will be contacted. We have a live answering service for after-hours emergencies, which are handled by the on-call therapist. Please call (801) 483-1600, option 0 and wait for representative.

**I, by virtue of my signature below, understand the risks and responsibilities noted above and agree to the inherent conditions implied or stated.**

Signature of Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_