

(PLEASE PRINT)

Patient Information

Patient: _____ Birthdate: _____ Today's Date: _____
Marital Status: Single Married Divorced Widowed Separated Gay Child
Gender: M F Social Security #: _____
Patient's Home/Mailing Address: Street: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (Primary) _____ (Secondary) _____
Please circle where CPS may leave messages to confirm appointments - PRIMARY SECONDARY
E-mail Address: _____
Responsible Party (if not patient): _____ Phone: _____
Address of Responsible Party: _____
Emergency Contact: _____ Phone: _____
Name of person or company who referred you to us: _____

Primary Insurance

Insurance Company: _____ Copay Amount? _____
Insurance Company Claims Address: _____
Insurance Phone #: _____ Group #: _____ ID #: _____
Subscriber Name: _____ Social Security #: _____
Relation to Patient: _____ Date of Birth: _____ Gender: M F
Address (if different from patients): _____
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 #: _____ ID #: _____
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:

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 make payment at the time of service, I understand that a \$10 processing fee will be assessed.

____ I understand that **appointments not canceled 24 hours in advance will result in a charge**. This fee is \$60. (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 35% 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: _____