CLIENT REGISTRATION PSYCHOLOGY OFFICE

9233 Ward Parkway, Suite 360 Kansas City, MO 64114 Phone (816)822-1922

Fax (816)822-2248

CLIENT INFORMATION

First appointment date ______________________________

FIRST NAME ________________________ MI _____ LAST NAME_____________________________________

ADDRESS____

CITY ____ STATE ________ ZIP_________________________

HOME PHONE (   ) ______________ WORK PHONE (   ) ______________ EXT: ____

CELL (   )______________

Therapist/Office may leave a message at (preferred #):____________________________________

May we contact you by E-mail? ___ Y ___ N E-mail Address: _____________________________

SOCIAL SECURITY # __________________________ BIRTH DATE ____________ SEX: ___M ___ F

Referred by: ________________________ **May we thank him/her for referring you?** ___ Y ___ N

EMERGENCY CONTACT

NAME ____ PHONE _____________________________________

ADDRESS ____________________________________ CITY, STATE & ZIP _____________________________

RESPONSIBLE PARTY INFORMATION

If someone other than the client is responsible for payment of this account, please enter that information below. If the client is a minor child and the parents do not live together, please provide information for ***both*** *parents.*

RELATIONSHIP TO CLIENT: ___________________________________ CUSTODIAL PARENT? ___ Y ___ N

FIRST NAME ____________________________ MI _____ LAST NAME _______________________________

ADDRESS ____

CITY _______________________________ STATE ________ ZIP __________ BIRTH DATE______________

Therapist/Office may leave a message at (best contact #): ____________________________________

EMPLOYER NAME ____

ADDRESS, CITY, STATE, ZIP ____

RELATIONSHIP TO CLIENT: ____________________________ CUSTODIAL PARENT? ___ Y ___ N

FIRST NAME _______________________ MI _____ LAST NAME __________________________

ADDRESS ____

CITY ____________________________________ STATE _______ ZIP ___________________

Therapist/Office may leave a message at (best contact #): ______________________________

EMPLOYER NAME ____

ADDRESS, CITY, STATE, ZIP ____

PLEASE TURN PAGE OVER AND COMPLETE INSURANCE INFORMATION

CONSENT FOR TREATMENT

I consent to the provision of psychological services for myself or the minor child or dependent named as patient.

SIGNATURE **X** ____ DATE ____________________

HIPAA AGREEMENT: **The Health Insurance Portability and Accountability Act (HIPAA) form has been made available to me.**

SIGNATURE **X** ____

INSURANCE COMPANY INFORMATION

If you would like us to file claims to your primary insurance company, please complete the information below and allow us to make a photocopy of your current insurance card.

PRIMARY INSURANCE COMPANY ________________________________ ID# ______________________

INSURED'S NAME ____________________________ SS# ___________________ DOB ____/____/____

CLIENT RELATIONSHIP TO INSURED: _____Self _____Spouse _____Child _____ Other

CLAIMS ADDRESS ____

____

INSURANCE ASSIGNMENT

I authorize the release of any medical or other information necessary to process claims filed on my behalf. I authorize payment of medical benefits to my psychologist or the billing service. I also request payment of government benefits to the party who accepts assignment as indicated on the insurance claim form.

SIGNATURE **X** ____ DATE ____________________

(I am the insured or custodial parent for the insured)

FINANCIAL AGREEMENT

CO-PAYMENT – I understand that my co-payment is due at the time of each appointment.

CANCELLATIONS – I understand that I am responsible for paying my therapist's hourly rate if I forget an appointment or do not give 24-hour notice of a cancellation. I also understand that my insurance does not cover such charges.

PHONE CONSULTATION – I understand that I will be charged my therapist's hourly rate for phone consultations.

ELECTRONIC COMMUNICATION – I understand that insurance will not cover electronic communications at this time.

INSURANCE FILING – I understand that if my insurance company has not paid for services rendered within **60 days,** it will be my responsibility to pay for such services and to follow up with my insurance company for reimbursement. If my account is more than **90 days delinquent**, it will be turned over to a collection agency, unless I make an acceptable agreement with my therapist. Our office and your therapist cannot assume responsibility for interpreting your insurance policy or for your specific insurance coverage.

Your signature below indicates your understanding of, and agreement with, the policies outlined above, and your agreement to pay your therapist for services rendered by him/her.

RESPONSIBLE PARTY SIGNATURE X ________________________________ **DATE** ____________

(I agree to pay in full for services provided)