Psychology Associates
OF GRAND RAPIDS, PC

Office Use Only
Acct#:_____
Provider: _____
ICD10:_____

Date: _____

Patient Name: _____ **Sex:** M F

First Middle Int. Last

Date of Birth: _____ **Social Security:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone 1: _____ **H/W/C** **Phone 2:** _____ **H/W/C**

Patient's Employer: _____

Primary Care Physician or Psychiatrist: _____

Address or Phone: _____

In the event that we need to contact you, may we:

Accounts must be kept current or statements will be mailed and calls will be made.

Leave a voicemail on above #'s? Yes _____ No_____ Send mail to home? Yes_____ No _____

Leave our name and number with another person at above #'s? Yes _____ No _____

FOR MINOR CHILDREN OR PATIENTS WITH GUARDIANS:

(The parent/guardian who is bringing the child to the appointments will be listed as the responsible party. Please list that parties name first)

Parent/Guardian #1: _____ **Relationship:** _____

Address: _____

Contact #1: _____ **Contact #2:** _____

Parent/Guardian #2: _____ **Relationship:** _____

Address: _____

Contact #1: _____ **Contact #2:** _____

Emergency Contact:

Name: _____ **Relationship:** _____

Phone: _____

PRIMARY INSURANCE COMPANY: _____

Name of Policy Holder: _____ **Sex:** M F

Relationship to Patient: _____ **DOB:** _____ **Soc. #:** _____

Contract/Member ID: _____ **Group #:** _____

Employer: _____

SECONDARY INSURANCE COMPANY: _____

Name of Policy Holder: _____ **Sex:** M F

Relationship to Patient: _____ **DOB:** _____ **Soc. #:** _____

Contract/Member ID: _____ **Group:** _____

Employer: _____

ALL COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

INSURANCE RELEASE: I authorize the release of any information my clinician may feel is necessary to process my insurance claims. This may include information about my mental health. I authorize participating insurance payments directly to my provider. I fully understand that I will be responsible for any amounts due following a response from my insurance, including deductible and non-covered services. I understand that if I have an insurance that Psychology Associates does not participate with that I am responsible for payment in full at the time of service and a courtesy claim will be billed on my behalf and any reimbursement will be sent directly to me from my insurance company.

_____ **Date:** _____

Signature of Patient/Parent/Guardian

Psychology Associates of Grand Rapids, P.C.
POLICY INFORMATION

We are thankful that you have chosen PAGR. We are committed to providing you with the highest quality, professional and ethical treatment. Please understand that payment of your bill is considered part of your treatment.
PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, OR VISA / MASTERCARD / DISCOVER / AMERICAN EXPRESS.

The following is Psychology Associate's policy information, which we require you to ***read, initial, and sign*** prior to any treatment. If you do not understand, or if you have any questions, please ask.

Confidentiality _____
All information disclosed within sessions is confidential and may not be revealed to anyone without your expressed, written consent. There are exceptions to confidentiality, specifically IN CASES WHERE THE THERAPIST IS MANDATED BY LAW TO REPORT TO THE APPROPRIATE AUTHORITIES (i.e. WHERE THERE IS REASONABLE SUSPICION OF ABUSE OF CHILDREN, ELDERLY OR DISABLED PERSONS; WHERE THE CLIENT IS LIKELY TO HARM HIM/HERSELF OR OTHERS UNLESS PROTECTIVE MEASURES ARE TAKEN). If you have any questions about confidentiality, especially as it relates to children and adolescents, please ask your therapist. Please note that if you use insurance to help pay for your sessions, your signature on the bottom of our intake sheet grants the insurance company permission to request information about you from us.

Insurance _____
We participate with several insurance companies. Participation means that we will accept what your insurance company approves. **You are responsible for any copays, deductibles or non-covered services at the time of service.** If we do not participate with your insurance company you are responsible for the full fee at the time of service. We will turn in a courtesy claim for you to your insurance so that they can reimburse you directly, apply the visit to your deductible, etc.

Payment for Services _____
Payment is expected at the time of the scheduled session unless you request other arrangements. If you are having difficulty paying your bill please talk with us regarding payment arrangements. If we receive payment other than expected from your insurance company, the remaining balance will be transferred to your account. Any outstanding balance must be paid in full within 30 days. We will mail a statement to all clients who have a balance due on their account. **If payment is not received within the calendar month, a $10 statement fee will be assessed.** If an account remains unpaid, we will pursue collection of this past due account.

Minor Patients _____
The adult accompanying a minor and/or the parents/guardians of the minor are responsible for full payment. For unaccompanied minors treatment will be denied unless charges have been pre-authorized to an approved credit card or payment is made by cash or check at time of service, unless prior arrangements have been made.

Cancellations / Missed Appointments _____
We request that appointment cancellations be made 48 hours in advance. Cancellations made less than 24 hours prior to the appointment or no show appointments may result in a charge that may total the full fee of your appointment.

Client Acknowledgement and Agreement:
* I have read and understood the above information.
* I have had the opportunity to ask questions and have any questions answered.
* I agree to pay the fee for each visit for services rendered.

_____ _____
Signature of patient or responsible party **Date**

_____ _____
Signature of co-responsible party **Date**

Psychology Associates of Grand Rapids, P.C.
& Affiliated Therapists and Psychiatrists

Notice of Privacy Practices Acknowledgement of Receipt

I acknowledge that I have been offered the Psychology Associates of Grand Rapids, P.C. and Affiliated Therapists and Psychiatrists Notice of Privacy Practices.

Print Patient Name

Patient or Patient Representative Signature Date