PATIENT INFORMATION TODAY'S DATE _____

Patient Name _____ DOB _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work _____ Cellular _____

Age _____ SSN _____ Male or Female Single Married Divorced Other

If applicable, the child is in legal custody of: Mother Father Both Parents Other-_____
If parents are divorced, please state custody split: _____% to _____ / _____% to _____

Employer or School _____

Primary Care Physician _____ Referring Physician _____

Individual(s) we can contact in the event of an emergency _____

Phone Number _____ Relationship _____

May we contact you and leave voice and/or text messages on your cellular or landline? Yes No

Email address: _____

GUARANTOR (IF PATIENT IS A MINOR, THIS PERSON WILL BRING THE MINOR TO THE APPOINTMENTS)

Name _____ DOB _____ SSN _____

Relationship to Patient _____ Employer _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

PRIMARY INSURANCE _____ **POLICY HOLDER** _____

SSN _____ Policy Holder's DOB _____ Policy ID # _____

Employer _____ Phone _____

SECONDARY INSURANCE _____ **POLICY HOLDER** _____

SSN _____ Policy Holder's DOB _____ Policy ID # _____

Employer _____ Phone _____

I have been informed of the Notice of Privacy Practice and Patient Rights and Responsibility of Psychological Assessment Specialists, PLLC. I am giving my consent, in case of an emergency, to contact my emergency contact listed above. By signing below, you or anyone accompanying you, agree to not bring firearms or any other dangerous weapons/substance onto the property of PAS. I understand that I have chosen Psychological Assessment Specialists as my mental health care provider. I am aware that a written copy of any of the above stated policies are available to me upon request. I attest, to the best of my knowledge, that the above information provided on this form is true and correct.

_____

Patient or Legal Guardian Signature Date

Please see reverse side

PAS FINANCIAL POLICY / INSURANCE CLAIM POLICY

Welcome to Psychological Assessment Specialists. Our clinic looks forward to assisting you and making your visit with PAS a pleasant one. We will do all that we can to properly collect insurance information and then bill your insurance, but please know that it is a courtesy to do so. Please inform us of any changes to your address, insurance policy, employment status, or any other information pertinent to collecting payment of services. Failure to do so causes erroneous billing procedures and prolongs the billing process. You will be responsible for your bill while the errors are being corrected. Please inform PAS of ALL your insurance policies. If you do not inform PAS as of a primary insurance, especially one that requires prior authorization or EAPs, the secondary may refuse to pay. If this occurs, you will be responsible for the entire bill.

Please READ and INITIAL in the boxes below:

☐ **1) You, the patient, are responsible for the payments of ALL SERVICES that you receive from PAS at the time of service. THIS INCLUDES, all Co-pays, deductibles, or co-insurance. It is your responsibility to know your insurance contract benefits, assure payments are made to PAS by your insurance, and to negotiate with your insurance over any disputed claims.**

☐ **2) Please note that mental health services may be part of, separate, or completely disallowed from your health insurance policy.**

☐ **3) If you do not have insurance coverage, payment is due at the time of services unless other arrangements have been made with the PAS Billing Specialist. Monthly payments are required to keep an account current. If paid in full on the date of service, in cash, you will receive a 20% discount.**

Attention Medicare Patients: You may request payment for any authorized Medicare benefits/service be made to you or on your behalf to PAS. By signing below, you are authorizing PAS to release any of your medical information to CMS and its agents necessary to determine benefits and process claims payable to PAS.

Our fees are determined in part by "usual and customary" methods and are considered fair and representative of fees in our geographic area. PAS will accept cash, checks, credit card or debit card transactions. Insufficient funds will be assessed a $20 dollar return check fee.

All accounts 60 (sixty) days past due will be assessed a FINANCE CHARGE of 1.5% each month, with a minimum charge of $1 (one) dollar. All accounts must be paid in full within 6 (six) months. If no payment is received after warning and reasonable efforts have been made to obtain payment, your account will be turned over to our collection agency, Medical Recovery Service.

Please feel free to discuss any questions or concerns you may have with one of our office staff. We will be happy to assist you and, if necessary, direct you to our Billing Specialist for assistance in payment arrangements. If you would like a copy of this policy, the front staff will provide one to you.

By signing below, I authorize (1) my insurance company(ies) to make payments directly to PAS, PLLC (2) PAS to release any information necessary to process any claim(s) on my behalf (3) I also understand that I am choosing PAS as my mental health clinic provider (4) you or any one accompanying you agree not to bring firearms, knives, illegal drugs, or any other dangerous substances into the clinic.

_____

Patient Name DOB

_____

Signature of Legal Guardian

_____

Person Responsible for the Account Relationship to Patient