Post and Associates

Identifying Information

Patient's name: _____ Date: _____

*Preferred phone: _____ Alternate phone: _____

*We will use this number for routine matters, such as schedule changes, reminder calls, etc.

Consent for Treatment

(check YES or NO for each)

YES	NO	
☐	☐	I have received, read and understand the *Disclosure Statement and Services Agreement* provided to me.
☐	☐	I have received, read and understand the *Privacy Notice provided to me*.
☐	☐	I have received, read and understand the *Limits of Confidentiality* provided to me.
☐	☐	I authorize the release of necessary information to the agency referring me to **Post and Associates**.
☐	☐	I authorize the sharing of relevant information among **Post and Associates** clinicians and support personnel.
☐	☐	I agree that services with **Post and Associates** may be terminated if I am untruthful about medication use, am currently misusing medications, and/or am actively accessing multiple medical providers/prescribers for prescription services.

Signature of Patient: _____

Payment Agreement

(check YES or NO for each)

Patient's name: _____

YES	NO	
☐	☐	I understand the fee for the initial session is $180.00, and subsequent sessions are generally $110.00 per 45-50 minute session. Fees for services are available upon request.
☐	☐	I understand that **Post and Associates** may file claims on my behalf and will accept third party payments on my account, but that I am responsible for payment of any unpaid balances on my account, subject to the terms of any agreement **Post and Associates** may have with my insurance provider.
☐	☐	I authorize the release of necessary information to process insurance or collection claims, and I authorize payment of claims directly to **Post and Associates**. I give **Post and Associates**. permission to submit my name and account information to a third party for collection of past due amounts for which I am responsible.

I agree to pay fees: ☐ in full at time of service ☐ full co-pay at time of service

Other arrangements: _____

Signature of Responsible Party: _____

How were you referred? _____

Jerry Post, Psy.D., PC

NEW PATIENT INTAKE

Patient's Name _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN #: _____

PRIMARY INSURANCE

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

Guarantor Name: _____ Guarantor's DOB: _____

Relationship to patient: _____

SECONDARY INSURANCE

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

Guarantor Name: _____ Guarantor's DOB: _____

Relationship to patient: _____

TERTIARY INSURANCE

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

Guarantor Name: _____ Guarantor's DOB: _____

Relationship to patient: _____

***__This sheet must be filled out in its entirety for insurance to be billed.__

__Thank you__