Jerry Post, Psy.D., PC

Patient Information

Patient's name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ SSN #: _____

Legal Guardian Information for Minor-Aged Patients

Responsible Party: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ SSN #: _____
Employer: _____ Work phone: _____
*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 **Jerry Post, Psy.D., PC**.
☐	☐	I authorize the sharing of relevant information among **Jerry Post, Psy.D., PC** clinicians and support personnel.
☐	☐	I agree that services with **Jerry Post, Psy.D., PC** may be terminated if I am non-compliant with treatment, untruthful about medication use, currently misusing medications, and/or actively accessing multiple medical providers/prescribers for prescription services.

Signature of Responsible Party: _____

Payment Agreement

(check YES or NO for each)

Name of Responsible Party: _____

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 other services are available upon request.
☐	☐	I understand that **Jerry Post, Psy.D., PC** 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 **Jerry Post, Psy.D., PC** 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 **Jerry Post, Psy.D., PC**. I give **Jerry Post, Psy.D., PC** 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: _____

PRIMARY INSURANCE

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

*Guarantor Name: _____ *Guarantor's DOB: _____

Relationship to patient: _____

**NOTE: Please complete only if information is different from "Legal Guardian" section on Page 1.*

SECONDARY INSURANCE

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

*Guarantor Name: _____ *Guarantor's DOB: _____

Relationship to patient: _____

**NOTE: Please complete only if information is different from "Legal Guardian" section on Page 1.*

TERTIARY INSURANCE

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

*Guarantor Name: _____ *Guarantor's DOB: _____

Relationship to patient: _____

**NOTE: Please complete only if information is different from "Legal Guardian" section on Page 1.*

How were you referred? _____

This form must be filled out in its entirety for insurance to be billed.

Thank you!