Associates of Springfield Psychological P. C.

Client Name:____ Gender:______________
(as it is listed with the insurance company)

Marital Status:________________ Birth Date: _____ /_____ /_____ Age:__________

Parent(s) or Guardian names if client is under 18 y.o.:____

Client's Full Address**:**____

Phone #: ___________________Cell #: ____________________Work #: ______________________

Email address: (we will not share with others)____

Emergency Contact Name and Phone #: ____

Employer/School: ____

PCP Name: _________________________________ Tel # : ______________________________

PCP Practice name:____

Address: ____

☐ Please check box if you **do not** currently have a Primary Care Physician **(PCP)**

Contact with Primary Care Physician (PCP)

Our practice emphasizes good communication among treating professionals and especially with your Primary Care Physician (PCP). We would like to send to your PCP a brief summary about why you are coming to our office, your diagnosis, medication (if prescribed here) and our treatment plan, as well as ongoing updates as indicated. By signing below you grant us permission to contact your PCP, while you are an active client with the practice.

Signature ___________________________________ ***Date*** __________________________
Client / Parent or Guardian

Client Agreement and Consent Form

Thank you for selecting the Associates of Springfield Psychological (ASP). This document is designed to ensure that you understand our professional relationship. Please read it carefully and sign it.

All therapists at ASP are licensed, professionally trained and experienced. The relationship with your therapist is a professional one. The contents of treatment are confidential with the following exceptions: a) your authorized disclosure to another party; b) if you are a danger to yourself or another; c) a judge's order to disclose information; or d) mandated child abuse reporting. As mandated reporters, we are required to report if a child is or has been abused, even if we do not see the child in a professional capacity. We are also mandated to report disclosure by a client admitting to abusing a child, even if that child is no longer in danger. By signing this form, you consent to have your therapist consult with ASP clinical staff if the clinical need arises and you also acknowledge that ASP support staff has access to all files. If you are referred to another professional within this practice, the clinical staff will consult regarding your case. Although we do not involve ourselves in legal proceedings, if court ordered we will do so as an expert witness and bill you directly as such.

Please note that any time a psychiatrist writes a prescription for medication or lab work, a treatment diagnosis will be included on the prescription form. If at any time or for any reason you are dissatisfied with our services, please inform your treating professional or the office manager so that your concerns can be addressed.

Payment Policy

Co-pays and unmet deductibles are due at the beginning of each session. If payment is not made at each visit, an additional $5 service charge will be added. Cash, personal checks, and Visa/MasterCard/Discover are accepted. Please immediately inform us of any change in your insurance plan. You will be held responsible for any session fees due if you have not informed us of insurance changes prior to those sessions.

(OVER)

Any unpaid balance that becomes 30 days overdue will be charged a finance fee of 1.5% per month. You are also responsible for all collection fees associated with outstanding balances. There is a $35.00 service charge for any returned checks. We require a credit card to be kept on file if you have a deductible plan or are seeking medication services. We will store your credit card information in the electronic "vault" of our billing system, which is as secure as Pay Pal and other similar accounts.

To pay for services insurance companies require clinical information relevant to the services provided. In most cases this is just a diagnosis, but sometimes we are required to provide additional information such as treatment plans, summaries of treatment, or copies of the clinical chart. By signing this Agreement, you agree that we can release the required information to your insurance company for payment to be made.

Psychiatric/Medication Services: Should you wish to receive psychiatric/medication services, a credit card is required and will be used to charge for your psychiatric services. Additionally, if you fail to attend your psychiatric appointment, or fail to cancel it within **48 business hours**, your credit card will be charged a fee depending on the amount of time you had scheduled with the prescriber. If you require a prescription refill before your next scheduled visit and your prescriber is willing to provide it, there will be a $25 charge for the prescription.

Therapy Sessions: Cancellations require **24 business hours** notice. Failure to attend your session (no show) or an untimely cancellation **WILL** result in your being charged at least **$45.**

Emergencies

As a client in our outpatient practice group, you are expected to manage your day-to-day functioning. However, in the case of an emergency in which you fear you may harm yourself or another, call our emergency coverage at 610-544-2110, extension 0. If it is after hours, follow the directions for emergency calls.

Sharing Information with Others

Our mission is to help you feel better and manage your life more effectively. With your written consent, we will share treatment information with other healthcare providers who are also treating you. **We will NOT provide any information regarding your treatment to non-healthcare professionals who seek your treatment information for non-treatment purposes.** This means, for example, that we will not release information for the purpose of any legal proceeding, child custody determination, disability, etc. Your signature below indicates that you understand and agree to these conditions.

Assignment and Release

I, the undersigned, agree to assign directly to Associates of Springfield Psychological (ASP), all insurance medical benefits, if any, otherwise payable to me or insurance policy holder for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if I don't pay by cash or check at the time of service, my credit card will be billed for my portion of the fee. I hereby authorize ASP to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all of my insurance submissions. If I am not the insurance policy holder, I agree to allow ASP to release whatever billing information is necessary for payment to be made.

Electronic Communication Devices

Should you choose to communicate with your treating professional via text or email, please understand that such communications **are not HIPAA compliant** (and therefore not ultimately secure). Therefore, we recommend that if you choose to communicate with your clinician via these methods, please limit the communication to scheduling and do not share treatment-related information. You may discuss this further with your therapist.

If over age 14, please indicate with whom we can discuss information concerning the scheduling of your appointments:

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I have read and understand the policies outlined above as well as the Policies and Practices to Protect the Privacy of your Health and the Member's Rights and Responsibilities Statement (copies may be requested).

____________________________**date**___________ ____________________________**date**___________

Client Signature (age 14 and above) ***Parent /Guardian signature if client is under 18***

(9/27/2016)