Client Information Sheet

Client Information

Name:

Address:

City, State, Zip:

Birthdate:

Phone:

☐ Home ☐ Cell ☐ Work

Email:

Insurance Information

Subscriber Name:

Subscriber SSN:

Subscriber Birthdate:

Employer:

Occupation:

Relation to Client:

Insurance Company:

Policy Number:
Found on Insurance Card

Group Number:
Found on Insurance Card

Is Client Covered by Insurance?

☐ Yes ☐ No

Additional Information

Referral Source:

Primary Physician:

Previous Therapist/
Counselor/Psychiatrist:

Reasons for seeking therapy at this time:

Medications you are currently taking:
Include all RX, non-RX, OTC, and Herbs

Terms and Conditions

As a courtesy to you, we file a claim with ONE insurance company on your behalf.
All payments and co-payments are due at the time of service.
My signature represents my understanding and agreement with all items above.
My signature represents my consent to be treated by Gina Stoffregen-Roak.

_____ _____

Signature of Client/Client Guardian

Date

Financial Policy

Thank you for choosing Gina Stoffregen-Roak for your mental health care. Successful outcome of your treatment is our goal. Please understand that responsible and timely payment on your account is considered part of your treatment.

We will gladly file your insurance as a courtesy to you. However, the bill is your responsibility and payment is expected at the time services are rendered. Your insurance policy is a contract between you and your insurance company, and we are not privy to that contract.

Usual and Customary Rates

The practice is committed to providing the best treatment of patients and charges are usual and customary for our geographical area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

- Diagnostic interview $150
- Individual 45 min. $100
- Individual 60 min. $125

Unfortunately, if you are late for your scheduled session, the time will not be able to be made up as another patient is scheduled immediately after you.

Telephone Sessions

If you have an emergency and need assistance, time on the phone will be billed at the same rate of $100 per 45-minute session and $125 for 60-minute session for all telephone discussions.

Missed Appointment

Unless your appointment is cancelled at least 24 hours in advance, the policy is to charge $100 for the scheduled appointment. Excessive cancellations and or 'No Shows' may result in termination from the practice. Your credit card on file will be charged or an invoice will be sent for remittance.

Monthly Billing Fee and Late Fees

Copay is required upon time of service in the form of check, cash, or credit card. In the event a personal check is returned for any reason, a charge of $35.00 will be added to your balance.

FMLA Paperwork

A fee of $25.00 will be charged for FMLA paperwork to be completed. There is a minimum of three sessions to clinically assess.

Limitations of Privacy

Federal law mandates that I report any suspicion of child abuse. Disclosure of information regarding the intent to harm another individual must be disclosed to protect the life of the individual (Tarasoff).

Your Rights

Your therapy is a significant investment in your health. Your opinions will be respected. You have the right to refuse any recommendation. You have the right to choose to discontinue therapy at any time. It is advised you discuss your plan to terminate your therapy with your therapist so we can terminate in a healthy manner.

I have read, understand, and agree with all the above items.

_____ _____

Signature of Client/Client Guardian Date

Emergency Contact Information

I _____, authorize the office of Gina Stoffregen-Roak, to contact the following people in the event of an emergency.

Please Provide Two Contacts

_____	_____	_____
Name	Relation to Client	Phone
_____	_____	_____
Name	Relation to Client	Phone

My signature represents my understanding of the agreement to this authorization.

_____	_____
Signature of Client/Client Guardian	Date

Authorization to Bill Insurance or Employee Assistance Program (EAP)

I authorize the office of Gina Stoffregen-Roak to bill my insurance company or employee assistance program for services scheduled at this office.

I authorize the office of Gina Stoffregen-Roak to charge my credit card on file for services rendered.

I understand that I am fully responsible for payment in full in the event my insurance does not cover my visit, or if I have not met my deductible. Payment will be made in the form of cash, check or credit card.

My signature represents my understanding and agreement with all items above.

_____ _____

Signature of Client/Client Guardian Date