

**Park Ridge Psychological Services**

36 Main Street, Ste. 106  
Park Ridge, IL 60068

<b>Patient Information</b>	<b>Insured Information (if different than patient)</b>
Patient's Name: _____	Insured Name: _____
Patient's Birthdate: _____	Insured's Birthdate: _____
Address: _____	Address: _____
City, Zip: _____	City, Zip: _____
Home Phone: _____	Home Phone: _____
Cell : _____	Cell : _____
E-mail: _____	E-mail: _____
Other: _____	Insured's Employer: _____
How would you like benefit information sent? Mail <input type="checkbox"/> E-mail: <input type="checkbox"/> Home Phone: <input type="checkbox"/> Fax: <input type="checkbox"/> ( _____ )	
Where and to whom would you like billing information sent? _____	
In order to save paper and postage, may we send monthly invoices to the e-mail you provided? YES <input type="checkbox"/> NO <input type="checkbox"/>	
If not, is there another e-mail address we may send invoices? _____	

<b>Insurance Company Information</b>
Name Of Insurance Company and Plan: _____
Insured's ID Number (Include Alpha Prefix): _____ Insured's Policy #: _____

<b>Credit Card Use:</b> (Circle) Visa Mastercard AMEX
Card # _____ Expiration Date: _____ Security Code (3 or 4 digits): _____
Please sign to authorize the following charges on this account:
_____ Charge all deductibles and co-payments to this card on a weekly basis.
_____ Charge all outstanding balances on a monthly basis.

**Default CPT:** \_\_\_\_\_ **Default Dx.:** \_\_\_\_\_

**Office Use Only**

Yearly Deductible: \$ \_\_\_\_\_ Amount of deductible met so far: \$ \_\_\_\_\_

Co-pay for Outpatient Mental Health: \$ \_\_\_\_\_ Maximum visits per year: \_\_\_\_\_

Authorization required? Number to call for pre-authorization: \_\_\_\_\_

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**INFORMED CONSENT FOR TREATMENT**

This form acknowledges that you have requested professional services from PRPS and sets forth the agreement concerning our understanding of such services.

1. You understand that these services involve evaluation/therapy, and whatever services are provided will be by mutual agreement between you and me.
2. If you participate in whatever services are recommended by me, you agree to pay for these professional services according to the fee schedule you have received.
3. I agree to pay in full all fees for services provided and I understand and agree that I am responsible for any charges that are not covered by insurance or any other third-party payor. I also agree to assist PRPS in submitting claims for insurance reimbursement.

**Fee Schedule:**

**Individual Therapy:** \$ \_\_\_ per 45' session (\$ \_\_\_ per 25', \$ \_\_\_ for 60') **Initial Assessment/Testing:** \$ \_\_\_/hour

**Letter Writing/phone consultation:** \$ \_\_\_ per 15 minute block      **Group Psychotherapy:** \$ \_\_\_/hour

4. I hereby request that payment of insurance benefits be made directly to PRPS. I authorize PRPS to release to insurance companies any information requested by them to determine their liability for claims submitted to them for reimbursement. This agreement covers the entire period of my relationship with PRPS.
5. I will charge you on the basis of expended time, and I reserve the right to terminate the relationship for non-payment. Any payments received from third parties (i.e., insurance) will be credited to your account; however, you are primarily responsible for payment of any outstanding balances. A credit card is required to be on file.
6. I acknowledge that any missed sessions will be charged the full fee on the credit card unless you call within 24 hours. Balances that go beyond 2 months will be charged in full to the credit card.
7. Returned checks: a \$20 service charge will be applied for checks returned by your bank for any reason. If two or more checks are returned, I will no longer accept checks from you and you will be asked to pay in cash.
8. Payment plans can be arranged, at your request.
9. In the event if becomes necessary to use the courts to collect any unpaid balance, you agree to pay reasonable attorney fees and any and all court costs which may be incurred.

Please sign this agreement so we have a mutual memorandum of our understanding. You may have a copy of this for your records.

/      /2013

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Patient or Guardian Signature

Date