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

Patient Information	**Insured Information (if different than patient)**
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___ E-mail:___ Home Phone:___ Fax: ___ (_____)

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_____ NO_____

If not, is there another e-mail address we may send invoices? _____

Insurance Company Information

Name Of Insurance Company and Plan:_____

Insured's ID Number (Include Alpha Prefix):_____ Insured's Policy #:_____

Credit Card Use: (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

Patient or Guardian Signature Date