Barbara L. Cohen, PsyD
Clinical Psychologist

REGISTRATION FORM

PATIENT INFORMATION:
Name:____
Address:____
Phone Number: (home)____
(cell)____
Preferred Phone Number (choose one): ☐ home ☐ cell
Date of Birth:____

PERSON RESPONSIBLE FOR THIS ACCOUNT:
Name of Subscriber:____
Subscriber Date of Birth:____
Relationship to Patient:____
Address: (if different than the patient's):____________________________________
Phone Number:____

INSURANCE INFORMATION:
Name of Insurer:____
Contract #:____
Group #:____

ADDITIONAL INFORMATION:
Emergency Contact: (name)____
(phone number)____
Referral Source:____

If you would like information released to a Doctor, provider, or other, please complete a Release of Information form.

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CONFIRMATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of my Privacy Practices is available for review. If you would like to read this material or if you would like a copy, please let me know.

Print Name:_______________________________________

Signature:____

Date:____

USE OF PRIVATE HEALTH INFORMATION

Please read and sign this form which outlines the use of private health information.

I maintain responsibility for billing insurance companies for services which I have provided. Information which is released to insurance companies varies and depends upon the specific information required by the contract between the patient and the insurance company. I provide information as required which typically includes dates of service, types of service, and diagnosis. Ordinarily payment is received for claims submitted. If there is a problem with receipt of this payment, I may seek help from a professional such as a billing service or an attorney. The information shared with either the billing service or attorney will depend on the type of problem. Only information which is needed to resolve the claim will be shared. If you do not want information shared, then you have the option of paying for the services yourself rather than having me submit a claim to your insurance company.

Patient/Guardian____

Date:_______________________________

Barbara L. Cohen, PsyD
PATIENT FINANCIAL RESPONSIBILITY

The patient/guardian is financially responsible for services received.

Financial responsibility can be met if your insurance benefits cover the services. Covered services are specific to your insurance plan. It is your responsibility to understand the benefits and requirements of your insurance plan. Denials by your insurance company due to lack of pre-authorization or referral are your responsibility. It is your responsibility to inform me of any changes to your insurance. Insurance companies determine and pay for only what is medically necessary. For example, services specifically related to a job, education, or legal proceedings may not be covered. You are responsible should your insurance company not pay for services.

If you choose to use insurance benefits to pay for services, I will be required to provide information, such as a diagnosis, to the insurance company. Other information may also be required. Once information leaves my office, I cannot control how it is used. If you choose to not have me share information with your insurance company and they do not pay for the service, you are responsible for the payment.

I expect you to come for your therapy sessions. Cancellations are understood to happen only occasionally. Routine cancellations will be discussed as a therapeutic issue and there may be a charge. If a cancellation is unavoidable, notice is required.

Cancellations require a minimum of two business days notice. If appointments are cancelled with less than two business days notice, you will be charged the full fee as insurance companies do not pay for services that are not received. Please inform me directly of a cancellation. I may not receive your voice mail or text message and then I will not know that you have asked to cancel your appointment. I will verify with you that I have received your request to cancel your appointment. If you do not hear back from me, I may not have received your message.

Your appointment is for a specific day and a specific time. If you request a change in the time or day of your appointment, you are still responsible for the originally scheduled appointment unless cancellation procedures were followed.

Payment is expected at the time of service unless specific arrangements are made in advance. I do not send out bills. If needed, due to insurance processing, I will inform you of an amount you owe either during an appointment time or in writing. There is no charge for the first letter. If your bill remains unpaid and I need to write additional letters, there is a charge of $15 per letter. If a balance remains unpaid greater than 30 days, interest or late fees may be charged. If your balance remains unpaid, I may seek help in collecting unpaid amounts from a collection agency or attorney. Any fees charged by the collection agency and/or attorney will be charged to the patient and are the patient's responsibility.

There is a fee for extended phone calls, texts, or emails or if phone calls, texts, or emails become frequent. In most cases, this is generally greater than 10 minutes in length. The fee will be based on time used and billed at my regular hourly rate. If these contacts become frequent, a fee may be charged even if less than 10 minutes.

There is a charge for extended travel time. Generally, travel time greater than 10 minutes total will be charged. The fee will be based on the time used and billed at my regular hourly rate.

If you request copies of information sent to another source, there will be a charge for copying and mailing. If I write a letter on your behalf, there will be a fee if it requires greater than 10 minutes of my time.

By signing below, you (the patient) acknowledge you understand and accept the policies I have outlined.

Patient/Guardian:____
Date:____

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Clinical Psychologist

GUARDING SECURITY OF CONFIDENTIAL INFORMATION

In order to comply with specific rules regarding HIPPA (Health Insurance Portability and Accountability Act of 1996), please review and sign a privacy and security health information document.

It is my policy to not release confidential information without specific consent by the patient or guardian.

The purpose of this form is to identify ways in which you (the patient) would like general information to be handled. This may include a response by email, return phone calls or calls I initiate to you, or text. Calls may be made to home telephone, voice mail, work telephone, or cell phone. Please be aware that wireless communication is vulnerable to breaches and may not be confidential. Please be aware that if you request that information be shared only with you directly rather than leaving a voice mail message, this may affect the timeliness in which I can respond to any requests you make.

By completing this information and signing this form, you (the patient) are authorizing me (Barbara L. Cohen, PsyD) to leave information pertaining to general information such as having received a phone call or request to make a return phone call.

Home telephone yes_______ no_______ n/a_________
Work telephone yes_______ no_______ n/a_________
Cell phone yes_______ no________ n/a_________
Voice Mail yes_______ no________ n/a_________

If you prefer, please indicate how you would like me to handle general information such as phone calls.

___

Please list names of any individual with whom you would prefer that I do not leave information:

___

Patient/Guardian Signature____
Date:_____________________________________

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Clinical Psychologist

CONSENT TO TREATMENT

By signing this form, you (the patient), are agreeing to enter into treatment with me as your doctor.

Patient/Guardian Signature:____

Date:____________________________________