Referred By:_____

To be filled out by TPC

THE PSYCHOTHERAPY CENTER

Onset Date:_____/_____/_____

NEW PATIENT INFORMATION

(Please Print)

ICD-10 CM CODE: F_____

Today's date: / / 2017	THERAPIST:

PATIENT INFORMATION

Patient's First Name	Middle Initial	Last	Email Address:		
Street address:		Apt#:	City:	State:	Zip:
Home Phone Number (can we leave a message?) ・yes ・no	( )	Work Phone Number (can we leave a message? ・yes ・no	( )	Cell Phone Number (can we leave a message?) ・yes ・no	( )
Social Security #: - -	Date of birth: / /	**AGE:**	Gender:	Marital Status: (circle one) Single / Mar / Div / Sep / Wid	

Are you employed? ・yes ・no Are you a full time Student? ・yes ・no Are you a part time Student? ・yes ・no

INSURANCE INFORMATION

Fill out below & Please Give Insurance Card(s) to Receptionist

Primary Insurance Name:

Id #:	Group #:	Insured person's First Name:	Insured person's Last Name:	
Street address: (if different)	Apt#:	City:	State:	Zip:
Phone Number: ( )		**Date of Birth of Insured person:** / /		Gender:
Employer:	Employer address:		Employer phone no.: ( )	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other _____

Tricare Patients: Branch of Service: **Active Duty** ❑ **Retired** ❑ **Rank**_____

Sponsor's Social Security Number - - **Sponsor's Date of Birth** / /

Is there a secondary insurance? ・Yes ・No (If yes please fill out below)

Secondary Insurance Company Name:

Id #:	Group#:	Insured person's First Name:	Insured person's Last Name:	
Street address: (if different)	Apt#:	City:	State:	Zip:
Phone Number: ( )				Gender:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other _____

EMERGENCY CONTACT INFORMATION

Name of relative (that we can contact in case of emergency):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to The Psychotherapy Center. I understand that I am financially responsible for any balance. I also authorize The Psychotherapy Center to release any information required to process my claims.

Patient/Guardian signature *Date*

The Psychotherapy Center

327 West 21st Street, Suite 205, Norfolk, Virginia 23517
Main Phone (757) 622-9852 Fax (757) 622-4033

Patient Responsibility:

- To furnish a current insurance card and to provide to your therapist: whether you have to be pre-authorized for treatment, if you have an annual deductible, the total number of sessions per year your insurer will reimburse, and your co-pay per session.
- To confirm all financial arrangements and to cover all payments and billing questions directly with your therapist.
- To be held directly responsible for any co-pay amount, as well as any insurance payment that The Psychotherapy Center (TPC) has not received from your insurer within 60 days.
- To make your payment at the beginning of each session. All payments are to be made at the front desk, before each session.
- Patient further understands and agrees if requested/ordered by third party or court to be responsible for all costs and expenses incurred including therapists charges, court costs and reasonable attorney's fees in connection with patient's medical records.

TPC Responsibility:

- TPC will file your insurance at your request. TPC will not be held responsible for any administrative error(s) in processing claims, or for denial of claims by your insurer, and shall not be used as an offset against your bill.

TPC Missed Session Policy: (Missed appointments are not reimbursed by any insurance company or EAP)

- **If your insurer allows a charge for missed sessions:**

Because your therapy appointment is reserved for you, **you are required to give 24-hour notice for cancellations or you will be charged the full fee for the missed appointment.** Cancellations must be called into our office directly and left on your therapist's voice mail

- **If your insurer does not allow a charge for missed sessions:**

Cancellations are expected 24 hours before your appointment time. If you do not cancel 24 hours before and/or do not show up for your appointment without cancelling on two occasions, you will be referred to your insurer for another therapist not in The Psychotherapy Center.

Collections:

- We will make every effort to work with you if there are financial problems. However, if your account should be sent to collections, you agree to pay all costs of collections including attorney's fees of 33 1/3% and 18% interest per annum from date services were rendered on unpaid balances accrued.
- You agree to pay $35.00 fee for any returned checks that you write to TPC.

Your Signature On This Contract:

- Indicates your agreement with the terms of this contract with TPC.
- Indicates your agreement that TPC may file insurance claims on your behalf, receive insurance reimbursements, and release information requested by your insurance company.

Your Privacy:

- This office is in compliance with all state and federal laws regarding your privacy. Our privacy statement is posted in the waiting room. You may ask the office staff for your own personal copy.

_____ _____/_____/_____

Signature of Patient/Parent/Guardian Responsible for Payment **Date**

_____

Print Name

THE PSYCHOTHERAPY CENTER
327 WEST 21ST STREET SUITE 205 NORFOLK, VA 23517
OFFICE PHONE NUMBER: 757-622-9852
OFFICE FAX NUMBER: 757-622-4033

Clinician Name: (print) _____

Clinician Signature_____

Date: _____/_____/_____

Authorization to Disclose Information to Attending or Primary Care Physician

Patient Information

Patient Name:_____
(Please Print) (Last) (First)

Social Security #:_____-_____-_____

Custodial Parent:_____
(If child is under 18)

Address:_____Apt#_____

City: _____ State:_____ Zip:_____

Date of Birth _____/_____/_____
(month) (day) (year)

Primary Care Physician Information

Name:_____

Address:_____

Suite #:_____

City:_____State_____Zip_____

Phone Number: ( )_____-_____

Fax Number: ( )_____-_____

Release for Coordination with Primary Care Physician:
For the purpose of coordinating care, my mental health provider may wish to release pertinent information about my current treatment to my primary care physician. This release shall be valid until (60) days after my last date of treatment or until the last time I revoke this release, which can be done at any time.

(Check one) I do ☐ I do NOT ☐ give permission to the provider named above at The Psychotherapy Center to release information about my current treatment to my primary care physician.

Patient (Custodial Parent) Signature:_____Date:_____/_____/_____

Witness Signature:_____ Date:_____/_____/_____

(TO BE FILLED OUT BY THERAPIST)

Date of Initial Visit: _____/_____/_____

Diagnosis:_____

Current Medication(s):_____

Presenting Problems/Symptoms: _____

_____

Treatment Plan/ Reccomendations:_____

_____

_____