IN STEP CLIENT INFORMATION

PLEASE PRINT ALL THE INFORMATION

Client Name: ________________________________Nickname:__________________Date:_____________

Address:____

City:___________________________________State:_____________________________Zip:_________

Age: _______________DOB: _____________________________ Sex: Female Male

Referred By: ____

Organization:________________________________

Client or Guardian Home Phone: ______________________________________

Client or Guardian Cell:____

Client or Guardian Email:____

Please check here if you do not want us to add your email to our enewsletter.

Guarantor: ____

Relationship:________________________________

If Patient is under 18 Please Provide the Following:

Parents Name: ____

Parent 1 Cell#: ___________________________________ Parent 2 Cell#:______________________________

Parent 1 Work#: _________________________________ Parent 2 Work#: ____________________________

Parent 1 Email: __________________________________ Parent 2 Email:_____________________________

In case the office is closed due to unforeseen circumstances, please provide the best contact information:

Name/Number: ____

GENERAL PAYMENT POLICY : You are required to make payment at the time of service. Keep in mind that a therapist does not receive compensation until your fee is collected. Please arrive at least 5 minutes prior to your session to complete this transaction. You will receive a receipt monthly to submit to your insurance carrier. Individual practitioners will provide a financial agreement pertaining to other treatment modalities.

IN STEP FINANCIAL AGREEMENT

GROUP PAYMENT POLICY : A prepayment charge will be levied prior to the group start date to hold your place in the group. You will also receive a document to sign regarding the specific financial policies for that group.

Evaluation for Services: $250

Stepping Stones Group Fee Per Session: $170

Group Therapy Fee Per Session: $105

DBT Group Therapy Fee Per Session: $120-200

Individual Therapy Fee Per Session: Varies

INSURANCE : Insurance is designed to reimburse you and is a contract between you and the insurance company. It is your responsibility to obtain insurance billing procedure information and forms as well as reimbursement schedules. If prior authorization is required for any type of appointment, it is your responsibility to make these arrangements. We will provide you with a statement so that you may use it to file your claims and, if your insurance company requires treatment update, we will be happy to provide that at your request. We do not file claims for any carriers. In Step bill is your responsibility.

I hereby acknowledge responsibility for this account and guarantee payment of all charges against this account. I understand that this account is my responsibility and not that of my insurance company.

Any balance that remains unpaid sixty (60) days after billing will be charged interest at a rate of 1.5% per month. If it becomes necessary to forward the balance to a third party collection agency or attorney to obtain payment, you will be liable for all costs of collection, including but not limited to reasonable attorneys fees and court costs, which will be added to the original amount due. I authorize the release of any necessary information including medical information to my insurance company in order to determine benefits to which I'm entitled.

Signature of Responsible Party____

Date______________________