TREASURE VALLEY PSYCHOLOGICAL SERVICES

PATIENT REGISTRATION

(Please print form and complete ALL information)

PATIENT INFORMATION (This section refers only to the patient)

Name _____ Gender ___ Age ___ Birth Date _____

Address _____ Race _____ Ethnicity _____

City _____ ST _____ Zip _____

Home Phone _____ Cell Phone _____

Marital Status _____ Soc Sec Num _____

Occupation _____ Work Phone _____

Primary Care Doctor _____ Referred By _____

E-Mail _____ Last Grade Completed _____

BILLING INFORMATION (Person responsible for bill/payment)

Check here if patient is responsible. ☐

Name _____ Birth Date _____

Mailing Address _____

City _____ ST _____ Zip _____

Home Phone _____ Cell Phone _____

Relationship to patient _____ Soc Sec # _____

Employer _____ Work Phone _____

INSURANCE INFORMATION

Please read and initial by the following 3 statements.

Check here if NO COVERAGE. ☐

_____ 1. If your coverage depends on a doctor's referral, or prior authorization from your insurance company, it is **YOUR** responsibility to obtain it.

_____ 2. Please list information for ALL insurance coverages for the patient. Failure to provide this information may result in your being liable for claims denied by insurance company for "failure to file claim in a timely manner."

_____ 3. Check your insurance policy for "deductibles," "waiting periods," or "pre-existing condition" clauses that may result in claim denial.

Primary Insurance Company _____

Mailing Address _____ Phone _____

City _____ ST _____ Zip _____

Policy/Member Number _____ Group Number _____

Policy Holder _____ Birth Date _____ Soc Sec # _____

If applicable, please complete "SECONDARY INSURANCE" and "THIRD INSURANCE".

Secondary Insurance Company _____

Mailing Address _____ Phone _____

City _____ ST _____ Zip _____

Policy/Member Number _____ Group Number _____

Policy Holder _____ Birth Date _____ Soc Sec # _____

Third Insurance Company _____

Mailing Address _____ Phone _____

City _____ ST _____ Zip _____

Policy/Member Number _____ Group Number _____

Policy Holder _____ Birth Date _____ Soc Sec # _____

ADDITIONAL INFORMATION

Names & Ages of Immediate Family Members (demographics): _____

Drugs/Medications Presently Being Used: See Attached List ☐

Medical/Health History (brief summary of history that could affect counseling/therapy): _____

Previous Counseling/Therapy: _____

Address to send statements to, if different from Billing Address: _____

Please read and initial by the following 3 statements.

_____ 1. WE WILL BILLYOUR INSURANCE COMPANY FOR YOU. IF WE HAVE NOT RECEIVED PAYMENT FROM THEM WITHIN 180 DAYS, YOU MAY BE RESPONSIBILE FOR PAYMENT, AND THE RECOUPMENT FROM YOUR INSURANCE COMPANY.

_____ 2. COPAYMENT IS DUE AT TIME OF SERVICE. ANY OTHER AMOUNT OWED BY YOU (DEDUCTIBLE, CO-INSURANCE, NON-COVERED PROCEDURES, ETC) WILL BE PAYED WITHIN 30 DAYS OF BALANCE-DUE-STATEMENT DATE (MAILED OUT DURING THE FIRST WEEK OF EACH MONTH).

_____ 3. I AM AWARE THAT FAILURE TO PAY COULD RESULT IN MY ACCOUNT BEING SENT TO COLLECTIONS. COLLECTION AGENCIES MAY/OFTEN REQUEST MY RECORDS AND CONFIDENTIAL INFORMATION. COPAYMENT AT TIME OF SERVICE, AND TIMELY PAYMENTS OF OTHER AMOUNTS DUE WILL HELP TO AVOID THIS POSSIBILITY.

WE CHARGE $75, PER HOUR OF APPOINTMENT TIME, FOR APPOINTMENTS NOT KEPT, OR CANCELLED WITHOUT 24 HOURS ADVANCE NOTICE (LATE CANCELLATION).

Emergency Exceptions

- The above may not apply in last-minute situations "beyond your control", i.e. a flat tire, or sick child. Other non-emergent situations, i.e. conflicting appointments, work meetings, etc, do NOT normally fit the "last-minute beyond your control" definition, and will not be exempt.
- We can waive the charge for late cancellations if you are suffering from an illness that is likely to be contagious, or if your illness could cause safety issues while driving to your appointment.
- Even in such emergency situations, you MUST still call to cancel for the charge to be waived.

I acknowledge the appointment no-show/cancellation policy, and understand that I will be billed directly $75, per hour of appointment time, for any appointments I don't show up for, or cancel without 24 hours advance notice.

I also acknowledge that failure to adhere to this policy may result in losing patient privilege to schedule appointments in advance.

_____ _____

(PATIENT OR LEGAL GUARDIAN SIGNATURE) (DATE)

In order for us to submit a claim for payment to us for services under your policy, we must have your authorization to release medical information to your insurance company.

I hereby authorize release of information necessary to file a claim with my insurance company, and ASSIGN BENEFITS, OTHERWISE PAYABLE TO ME, TO THE DOCTOR OR GROUP ON THE CLAIM.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

(A copy of this signature is as valid as the original.)

_____ _____

(PATIENT OR LEGAL GUARDIAN SIGNATURE) (DATE)

YOUR PRIVACY

As Behavioral/Mental Health providers, we may at times consult with other psychologists, counselors, or mental health providers. During these consultations, your anonymity will be protected.

(PATIENT OR LEGAL GUARDIAN SIGNATURE) (DATE)

PSYCHOTHERAPIST-PATIENT SERVICE AGREEMENT

(Click on "HIPAA" link to read this document prior to signing this block.)

Your signature indicates you have read, or had the opportunity to read, the information in this document, and agree to abide by its terms and conditions during your professional relationship with our facility.

(PATIENT OR LEGAL GUARDIAN SIGNATURE) (DATE)

PATIENTS OF: DR. M. SNIDER, PhD
DR. RACHEL A. ROOT, PhD, LPC

- These providers do NOT engage in legal cases on behalf of her patients.

(PATIENT OR LEGAL GUARDIAN SIGNATURE) (DATE)

PATIENTS OF: ALL PROVIDERS

- Do you have ANY MEDICAID coverage or benefits. Circle one, then sign: YES NO

(PATIENT OR LEGAL GUARDIAN SIGNATURE) (DATE)