

Giles, Haderlie & Associates

FAMILY PSYCHOLOGY

330 East 400 South #3 • Springville, Utah 84663 • Phone: (801) 491-6394 • Fax: (801) 491-6613

Patient Information

CODE (office use only): _____

Patient Full Name: _____ Referred By: _____

Date of Birth: _____ Gender: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Phone Number: _____ Type: _____

Appointment Reminder Preferences (circle two): Home Cell Cell (text) Email

Marital Status: _____

Highest Level of Education: _____

Members of the Household	Age	Gender	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications currently being taken: _____

Prescribed By: _____

Previous Counseling: Yes No If yes, with whom? _____

Primary Emergency Contacts

Primary Emergency Contact: _____ Phone Number: _____

Additional Emergency Contact: _____ Phone Number: _____

Insurance Information:

Insurance Company: _____ Effective Date: _____

Policy Holder: _____ Date of Birth: _____

Relationship to Patient: _____ Phone Number: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Policy Number/ Member ID: _____ Group Number: _____

IF OPTING NOT TO USE INSURANCE (please circle your payment plan): Ecclesiastical Out of Pocket

If ecclesiastical leader is paying, please fill out the following:

Ecclesiastical Leader's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

By signing below, I state that all information listed above is correct and current:

Name (Please Print)	<div style="background-color: yellow; width: 100%; height: 20px; margin-bottom: 5px;"></div> Responsible Party Signature	Date
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Enforced Policies of Giles, Haderlie and Associates Family Psychology:

Please read and initial each office policy below to indicate your understanding and acceptance of policy.

Confidentiality: Federal guidelines require us to provide notice to you about how your Protected Health Information (PHI), both psychological and medical, may be used and disclosed by our office. Signature below authorizes GHAFP to release any information required by your medical insurance company/third party payer for payment of services. GHAFP is also legally required to share information in certain cases if we have reason to believe that you are in imminent danger of harming yourself or someone else, or if we become aware of a case of child abuse or the abuse of a vulnerable adult. You have been given a summary of PHI information upon your first visit, and a more complete explanation of the federal guidelines is available upon request.

Canceled or Missed Appointments: If you need to change or miss an appointment, please provide 24 hours notice by calling the office at (801) 491-6394. Canceled or missed appointments without 24 hours notice are subject to **cancellation fee of \$50.00. Please be aware that if you miss two or more appointments in a row without any notice all remaining scheduled appointments may be cancelled.** Appointments are scheduled for either 45 or 55 minutes. Occasionally, these sessions may extend beyond the set time, however they may also end before the set time when deemed appropriate by the therapist.

Payment Policies: Payment of fees is ultimately the responsibility of the client. Giles & Associates will bill third parties as a service to our clients, but it is the client's responsibility to know and understand the mental health benefits, monitor the outstanding balance, and ensure that the balance is paid.

Co-pays: Your co-pay is due at the time of service. If you do not know your co-pay amount, \$25.00 will automatically be charged at time of service.

Out of Pocket Discount: An Out of Pocket Discount is available for clients who wish to pay for the service in full at the time of the service.

Late Payment Fee: A \$10.00 Late Fee will be added to any account balance after 45 days of the scheduled service.

Returned Check Fee: Any check returned unpaid is subject to a \$20.00 returned check fee.

Cancellation Fee: Appointments cancelled without 24 hours notice or missed are subject to a **\$50 cancellation fee.**

Testing Results: Test results and other correspondence will not be released until account balance is paid in full.

Collections: A 30% collection fee plus reasonable attorney(s) fees will be added to any account turned over to a collection agency.

Reminder Calls: Giles, Haderlie & Associates Family Psychology has partnered with a company to send reminder notifications to our clients for their appointments. However, these are a **COURTESY. If you do not receive a call or other form of reminder and miss your appointment, you are still required to pay the \$50.00 cancellation fee.**

By signing below, I agree to all of the policies listed above:

Name (Please Print)

Responsible Party Signature

Date

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Payment Policy:

I understand that if I have insurance, my co-payments/co-insurance is due at the time of service. Insurance co-pays vary significantly and I understand that my co-pay amount may change after claims are submitted. If my insurance company requires me to meet a deductible before they pay for services, I will pay the contract amount for services in full until my deductible is met. I understand that Giles & Associates Family Psychology will bill my insurance as a service, but that I am ultimately financially responsible for all services rendered.

If I do not have insurance or if my provider is not contracted with my health plan, I agree to pay in full at the time of service.

By signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.

I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I understand that it is my responsibility to be familiar with the **mental health benefits** of my insurance plan. It is my responsibility to get preauthorization for services as required by my insurance company. If my insurance company denies payment because I did not obtain the proper pre-authorization, I understand that I am responsible for payment of services.

By signing below, I acknowledge that I have received this information and accept the terms of this contract. I further agree to assign my insurance benefits to Giles, Haderlie & Associates Family Psychology for services rendered.

Printed Name _____

Signature _____

Date _____