Shelley Bresnick, Psy.D.
Licensed Clinical Psychologist

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CLIENT INFORMATION

Date:_____ *Office Use Only: Dx:*_____

PATIENT:

Last Name: _____ First Name: _____ MI: _____

Parents'/Guardians' Names:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ email: _____

DOB: _____ Sex: F___ M___ Relationship to Insured: _____

Age: _____ Occupation: _____ Education (# of years): _____

Primary Care Physician: _____ Phone: _____

Current Medications/Dosage: _____

Referred By: _____

INSURED/GUARANTOR (Holder of insurance):

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Pager: _____ Cell Phone: _____

DOB: _____ Sex: F___ M___ SSN: _____

Employer: _____ Phone: _____

Employer's Address: _____

PRIMARY INSURANCE:

Name of Insurance Company: _____

Billing Address: _____

Phone: _____ ID#: _____ Group #: _____

Insured's Last Name: _____ First Name: _____

DOB: _____ Relationship to Insured: _____

SECONDARY INSURANCE:

Name of Insurance Company: _____

Billing Address: _____

Phone: _____ ID#: _____ Group #: _____

Insured's Last Name: _____ First Name: _____

DOB: _____ Relationship to Insured: _____

Emergency Contact/Relationship: _____ Phone: _____

Payment Terms and Agreement:

1. I understand that payment for charges is due on the date of service, with the exception of insurance carriers for which Shelley Bresnick, Psy.D. is under contract to file claims directly.

2. I understand that if I cancel an appointment with less than 24 hours notice, I will be responsible for half the session fee. If I do not keep an appointment and do not notify Dr. Bresnick, I will be responsible for the total amount of the session fee.

3. I understand that my insurance coverage may not provide payment for all charges incurred. I will be responsible for any co-payment, deductible, or service not covered by my insurance carrier. If I do not have insurance coverage or desire to not use my insurance coverage, for services rendered by Dr. Bresnick, I agree to pay all charges resulting from such services.

4. I hereby authorize Shelley Bresnick, Psy.D. and Medical Billing Services to file claims for services rendered with my insurance carrier, and I assign payment of mental health benefits to Dr. Bresnick. I authorize the release of medical information necessary to process insurance claims for current and future services. I understand that my insurance carrier may not authorize all services desired or provide payment for all charges incurred, if I do not wish certain information to be shared with my insurance carrier. In the event that my insurance carrier fails to pay Dr. Bresnick for services rendered within 60 days of claim filing, I understand that I may be billed for these charges, with payment due within 10 days.

5. I will keep my account current as to charges for which I am responsible. I understand that a $5.00 charge will be assessed on balances that have not been paid within 45 days. I understand that after 45 days, the $5.00 charge will be assessed on a monthly basis. If the balance due becomes older than 60 days, Dr. Bresnick is entitled to take action necessary to collect such charges, and I will be responsible for all fees and costs incurred as a result of such collection.

Signature: _____ Date:_____

(Person Responsible for Payment)

Printed Name:_____