21625 Chagrin Blvd., Suite 230
Beachwood, OH 44122
Phone: (216) 795-5396 Fax: (216) 795-5382

PATIENT INFORMATION FORM

TODAY'S DATE: _____

Patient Name: _____ DOB: _____ Age: _____
(Please Print)

☐ Male ☐ Female ☐ Other SSN: __ __ __ - __ __ - __ __ __ __ Marital Status: _____

Address: _____ Phone: _____☐
(Street) (Home)

_____ _____ _____☐
(City) (State) (Zip Code) (Cell) (Check Preferred)

Email Address: _____

Guardian: _____ Phone: _____
(If Applicable) (Preferred Phone Number)

Emergency Contact: _____ _____ Relation to Patient: _____
(Name) (Phone Number)

Insurance Company: _____ Policy No.: _____

Mental Health Carrier: _____ Group No.: _____
(If Different from Primary Insurance Carrier)

Name of Policy Holder: _____ Policy Holder DOB: _____

☐ Male ☐ Female (Check One) SSN: __ __ __ - __ __ - __ __ __ __ Relation to Patient: _____

Were you referred by a physician: Yes ☐ NO ☐ Physician Name: _____

Physician's Address: _____ Phone: _____

_____

PROFESSIONAL SERVICES AGREEMENT

I understand that the effectiveness of mental health services depends on efforts of the patient as well as those of the practitioner (Psychologist) and I promise to make my best effort to comply with these procedures. These best efforts will include open and honest discussion of my thoughts and feelings, as well as an effort to perform any exercises or homework assignments that may be recommended. I also agree to return, undamaged, any materials that have been loaned to me as part of the procedures and understand that I am liable for the cost of these materials. I understand that the effectiveness of the procedures cannot be guaranteed and that the Psychologist has sole professional responsibility for all services provided.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the Psychologist/Therapist at least two weeks in advance so that effective planning for continued care can be implemented. I also agree to notify the Psychologist at least 24 business hours in advance if I will be unable to attend any session. I understand that if I fail to make such notification, I may be charged for up to the full cost of the session, which will not be reimbursable by my insurance company. I agree to be responsible for these charges.

(Continued on Reverse Side)

I understand that conversations with the Psychologist/Therapist will be of a confidential nature. I authorize my Psychologist/Therapist to discuss my treatment with other treatment providers to coordinate my care. I further understand that the Psychologist/Therapist, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the Psychologist/Therapist has a legal responsibility to protect anyone that the patient may threaten with violence, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the Psychologist/Therapist will make reasonable efforts to resolve these situations before breaking confidentiality. I also understand that in order to ensure patient confidentiality and privacy, electronic recording is strictly prohibited within the Psychologist's office.

My signature below indicates that I have agreed to these terms and have read and understood the "Notice of Privacy Practices" and a "Welcome to our Practice" informational flyer describing my rights and responsibilities as a patient or guardian.

X _____ _____

(Signature of Patient or Guardian) (Date)

FINANCIAL AGREEMENT

Patients are responsible for providing accurate information about their insurance benefits. Failure to complete this section or inaccurate' information will make patients fully responsible for all charges. Patients are responsible for notifying GRBH or the Psychologist of any changes in insurance within 30 days; otherwise, you will be responsible for payment in full. In most cases, patients are responsible for making the initial phone call to their insurance companies. This form will be kept on file for one year from date of signature; patients must complete this form on an annual basis.

I request that GRBH, as the agent for the Psychologist/Therapist, submit bills to the insurance company that I have listed on the Patient Information Form, and I grant permission to the Psychologist and GRBH to release such confidential information as is necessary to obtain payment from the insurance company. In the event that my insurance company fails to observe Ohio prompt pay standards or otherwise fails to adhere to relevant rules and standards, I grant permission to GRBH to share information related to my insurance claim with the Ohio Department of Insurance.

I understand that I am financially responsible for the cost of the mental health services to me and for any portion of the fees not reimbursed or covered by my health insurance. I understand that my copay is due at time of service, otherwise a $10 billing fee may be charged each time for any bill that is sent if I have an outstanding patient balance. If my mental health care is provided under the terms and conditions of a managed mental health care program to which the Psychologist/Therapist is contracted, my financial responsibilities may be limited by the terms of that contract. I understand that my failure to pay these bills may result in collection procedures (including court proceedings) being taken against me by the Psychologist/Therapist or a collection agency contracted by the Psychologist/Therapist to collect these bills. I also understand that if my account is placed in collection procedures, I may not be able to schedule appointments.

I understand that I must contact my insurance company directly if I wish to know the specific contract rate my carrier has with GRBH.

I authorize the release of any medical information necessary to process my claim.

My signature below indicates that I have agreed to the above terms.

X _____ _____

(Signature of Patient or Guardian) (Date)

FINANCIAL RESPONSIBILITY

(If Other Than Patient)

Name: _____ DOB: _____ ☐ Male ☐ Female

(Please Print)

Address: _____ SSN: _____

(Street) (Home)

_____ Phone: _____

(City) (State) (Zip Code)

Signature of Financially Responsible Party: _____

Date: _____