**ADULT INFORMATION SHEET**

PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(FIRST) (MIDDLE) (LAST)

SOCIAL SECURITY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_\_\_\_\_\_\_\_

( ) SINGLE ( ) MARRIED ( ) SEPARATED ( ) DIVORCED ( ) WIDOWED ( ) PART TIME STUDENT ( ) FULL TIME STUDENT ( ) DISABLED

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET CITY ZIP

HOME #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF AN EMERGENCY FAMILY MEMBER TO CONTACT:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET CITY ZIP

PLACE OF EMPLOYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DEPT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I AGREE TO ASSUME FULL RESPONSIBILITY FOR ALL CHARGES INCURRED FOR SERVICES RENDERED TO THE PATIENT REGARDLESS OF INSURANCE COVERAGE. IT IS FURTHER UNDERSTOOD AND AGREED THAT ANY FAILURE TO COMPLY WITH THIS AGREEMENT WILL RESULT IN A COLLECTION EFFORT, BE THAT OF A COLLECTION AGENCY OR SMALL CLAIMS COURT. THE FEES INCURED FOR THIS COLLECTION EFFORT WILL BE AT THE GUARANTOR’S EXPENSE. FOR ANY MANAGED INSURANCE CARRIERS, GUARANTOR WILL BE RESPONSIBLE TO LET OUR OFFICE KNOW OF ANY SESSIONS OR LABWORK DONE OUTSIDE OF OUR OFFICE. YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL FOR ANY SESSIONS NOT NOTED. YOU WILL ALSO BE BILLED FOR ANY SESSIONS NOT CANCELLED 24 HOURS IN ADVANCE. YOUR INSURANCE CARRIER WILL NOT PAY FOR MISSED APPOINTMENTS.**

GUARANTOR’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INSURANCE INFORMATION**

Your insurance policy is a contract between you and your insurance carrier. Even though we have agreed to work with your insurance, we will still look to you for final payment. To avoid any misunderstandings and possible embarrassment, the patient and/or responsible party is requested to complete the following:

1. **PRIMARY INSURANCE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Company Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policyholder’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_

**ID Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group Number:** \_\_\_\_\_\_\_\_\_\_\_\_

1. **SECONDARY INSURANCE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Company Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policyholder’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_

**ID Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group Number:** \_\_\_\_\_\_\_\_\_\_\_

1. **ADDITIONAL INSURANCE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Company Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policyholder’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_

**ID Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group Number:** \_\_\_\_\_\_\_\_\_\_\_

I request that Payment of Authorized Benefits be made on my behalf to my provider for any services rendered. I authorize the release of any medical information necessary to determine these benefits payable for related services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Guarantor’s Signature Date

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist/Dr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# CLIENT’S INFORMED CONSENT

I have chosen to receive treatment services by the above provider. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that CPA, LLC provides administrative services only and that my provider is responsible for treatment.

I also understand that the providers rotate emergency and after hours call.

I understand that psychotherapy is a cooperative effort between me and my therapist and that I need to work to resolve my own difficulties with my therapist’s guidance and assistance. I understand that my improvement cannot be guaranteed but will be the mutual goal between me and my therapist.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that mental health professionals are not allowed to release any information about clients unless they sign a “Release of Information” form which permits the transfer of specific information to a specified individual or organization. This form is valid for the time specified on the form.

There are certain situations in which information about clients may be released with or without their permission. The law requires therapist:

1. To report suspected child physical or sexual abuse or neglect to the proper authorities.
2. To report suspected abuse or neglect of a vulnerable adult.
3. To take action when a client is a danger to himself/herself or to another identified.
4. To respond when a court of law orders the release of inform.
5. To share, upon request, information and/or records about a minor child’s treatment with the non-custodial parent.

In addition, it is important to understand that your insurance company may request information in order to approve reimbursement for sessions. Your use of your policy constitutes consent to provide this information.

I understand that if my insurance refuses to approve sessions, but I wish to continue therapy, then I will be personally responsible for payments. Additional services, such as letters and reports for attorneys, court, and schools, lengthy telephone consultations or educational evaluations not covered by insurance, and fees for missed appointments may be charged to my account. I understand that I will be personally responsible for any of these charges not covered by my insurance.

## EMERGENCY COVERAGE

Your therapist can be reached during office hours at 873-1958. After hours you can reach the therapist or doctor on call by calling the same number and following the instructions for emergencies. Other emergency resources include your family physician, a local hospital emergency room, or the mental health center (873-9347).

**I HAVE READ AND UNDERSTAND THE ABOVE CONSENT.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature Parent/Guardian Signature (if Client is a Minor) Date  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  
Witness’ Signature Date

708 Mobjack Place Newport News, Virginia 23606

Phone: (757)873-1958 Fax: (757)873-2143

**PRIMARY CARE OR REFERRING PHYSICIAN NOTIFICATION**

Authorization for Release of Information:

I understand that my records are protected under the applicable state law governing healthcare information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke my consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Colonial Psychiatric Associates, LLC:

Print Patient’s or Guardian’s Name

Please check one:

* To exchange any applicable information with (my/my child’s) Primary Care Physician (PCP) or Referring Physician.
* Please DO NOT release to (my/my child’s) Primary Care Physician (PCP) or Referring Physician.

Patient’s Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (circle one): self parent guardian other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE DO NOT WRITE BELOW THIS LINE**: \_\_\_\_\_\_\_\_

Dear Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ this patient/family was recently seen in this office. I trust that the following information will be helpful in coordinating this patient’s care. I’ll contact you in the future if there is further information to share.  
  
Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of initial consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Provisional Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Presenting Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Treatment Recommendations/Plan/Follow-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Please call if additional information would be helpful at this time:  
  
Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
708 Mobjack Place Newport News, Virginia 23606  
Phone: (757)873-1958 Fax: (757)873-2143

**HIPAA ACKNOWLEDGEMENT**

This notice describes how Protected Health Information (PHI) about patients and their family members may be used or disclosed and how you can access this information. Colonial Psychiatric Associates, LLC (CPA) is providing this information to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review this notice carefully. Check the appropriate box and sign this form to give us permission to file claims with your insurance company and to confirm that you have read the notice of CPA Policies and Practices to Protect the Privacy of your Health Information.

**DOCUMENTATION OF PATIENT AUTHORIZATION**

\_\_\_\_\_I have read the above-mentioned notice and understand that limitations may be imposed on confidentiality for services received at CPA. I hereby accept these limitations on confidentiality and consent to receive services under these conditions.

I do \_\_\_\_\_ do not \_\_\_\_\_ give consent for claims to be submitted for third party reimbursement (for example, your insurance company). **If I check “do not,” it is because I will personally pay for service rendered at CPA.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient Name Signature (If adult)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Parent or Legal Guardian (if applicable) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Relationship



708 Mobjack Place Newport News, Virginia 23606  
Phone: (757)873-1958 Fax: (757)873-2143

**FINANCIAL POLICY**

You are responsible for all charges incurred by you for professional service rendered by your provider at Colonial Psychiatric Associates, LLC whether or not the services are covered by health benefits. Your insurance benefits are a contract between you and your insurance company. Your insurance company is responsible to you, not your provider. We will bill your insurance at no additional charge for services rendered at this office. We will not accept responsibility for collecting or negotiating insurance claims. You are responsible for payment within a reasonable time, regardless of the status of a claim. If your insurance company has placed your claim in a “pending” status that results in a delay in payment, you are to establish a payment plan. The charges for services are as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| Initial Visit | $170.00 | Letters/forms filled out | Set by provider |
| Individual Therapy | $120.00 | Medical Record copies | $15.00 plus copy |
| Family Therapy | $120.00 | Late Cancellation fee | Set by provider |
| Psychological Testing | $150.00/hour | Missed Appointment fee | Set by provider |

Appointments are scheduled and expected to be kept unless **24 hour advanced** notice has been given. After office hours, there is an answering machine available to leave a message. This allows us to fill appointments from our waiting list. Insurance companies do not cover missed appointments. This will be your responsibility. Repeated missed appointments could result in your provider referring you to another provider outside our office.

The undersigned states they have read, or had read to them, this Financial Policy and they understand that payment is due when services are rendered unless prior arrangements are made. Upon default of payment, the undersigned agrees to pay all reasonable legal fees and costs of collection to the extent permitted by law.

I, AUTHORIZE, any physician, medical practice, hospital, clinic or other medically related facility, insurance or reinsuring company, consumer reporting agency, social services or employer having information available as to diagnosis, treatment, prognosis and/or benefit coverage with respect to any physical or mental condition and/or treatment of me, my minor child or anyone I am signing for as their Legal Representative to give a representative of Colonial Psychiatric Associates, LLC or my provider any an all information required to properly process claims arising from treatment and care provided at Colonial Psychiatric Associates, LLC by my provider. A copy of this document shall serve with the same force as the original. This release includes information concerning alcohol or drug abuse as well as information concerning Hepatitis A, B, or C and HIV status that may be included in my medical records.

Print Patient Name Patient/Guardian Signature Date

SSN DOB Age