

# Psychology Specialists

- 1015 S. Mercer Road, Bloomington, 61701
- 808 Eldorado Road Ste 102, Bloomington, 61704
- 2502 E. Empire Suite C, Bloomington, 61704
- 2200 Ft Jesse Road Ste 130, Normal, 61761
- 2200 Ft Jesse Road Ste 210, Normal, 61761

- Dr. Seth Hatlelid,  Dr. Valerie Weck,  Dr. Paul Willett
- Sherry Yoder
- Dr. Michael Kahwaji,  Dr. Jennifer Koch,  Dr. Anna Czipri
- Diana Mariani,  Jody Seip
- Dr. Phillip Foster

Diagnosis: \_\_\_\_\_

## Patient Information

Patient Name \_\_\_\_\_ Sex:  M  F

Street Address \_\_\_\_\_ Marital Status (circle one) M S D W

City \_\_\_\_\_ Birth Date \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Patient SS# \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Employed:  Yes - FT  PT

Work Phone(\_\_\_\_) \_\_\_\_\_  No - Retired  Disabled  Not Emp

Cell Phone(\_\_\_\_) \_\_\_\_\_ Employer Name \_\_\_\_\_

Referring Physician \_\_\_\_\_ Student: Yes  No

Referring Physician Phone: \_\_\_\_\_ School Name \_\_\_\_\_

Does your insurance require a Preauthorization? Yes  No

If so, What is your Authorization #? \_\_\_\_\_ Number of Sessions \_\_\_\_\_ Date: \_\_\_\_\_

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## Billing Information      Is this a Work Related injury? Yes No      Auto/Liability Claim? Yes No

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If **yes to either**, please ask your provider for a worker's comp/accident form to fill out and we would be happy to bill them. Please note, if we do not have this information, you will be responsible for the session.

### **INSURANCE Information: A copy of all insurance cards (front and back) is needed:**

Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

**If Insurance Policyholder is NOT the patient, please provide the following on the policyholder:**

#### **Primary Policyholder's**

Full name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Birth Date \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Phone(\_\_\_\_) \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone(\_\_\_\_) \_\_\_\_\_ Full Time  Part Time

#### **Secondary Policyholder's**

Full name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Birth Date \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Phone(\_\_\_\_) \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone(\_\_\_\_) \_\_\_\_\_ Full Time  Part Time

# Patient Financial Policy for Psychology Specialists

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

**Commercial Insurance Carriers:** We bill insurance carriers for you if the proper paperwork is provided to us. Please complete the Patient Information Sheet provided to you. You are required to present a valid insurance card at the time of service. If your insurance has changed it is your responsibility to inform your provider and present a new insurance card.

**Worker's Compensation:** If your visit is work-related we will need the date of injury, case number, carrier name, address and phone number, adjustor and attorney information, in order to bill your worker's compensation insurance company.

**Medicaid:** The State of Illinois only allows patients to see doctors in the state supported facility unless they are willing to pay out of pocket for their sessions. Please let your provider know if you have Medicaid and ask them to fill out the Medicaid form for your visits.

**Assignment of Insurance Benefit:** In Consideration of services rendered by Psychology Specialists, I hereby assign, transfer and set over to Psychology Specialists all of my rights, title and interest to healthcare reimbursement. In the event that payment is received from more than one source causing overpayment for this period of service, I authorize application for the overpayment to any unpaid pain management bill for which I am responsible. I further agree to pay the account in full within 30 days from the date of billing unless satisfactory arrangements are made with the Office Manager of Psychology Specialists. Should the account be referred to any attorney or collection agency for collection, I agree to pay the agency fee or the attorney fee of thirty-three percent of the balance referred.

I hereby authorize Psychology Specialists to release to any insurance carrier coded diagnostic and procedural information necessary for the completion of my claim for payment purposes, as each entity has a separate billing department. I authorize Psychology Specialists to discuss details of my treatment with my insurance carrier and/or designated review agent. This assignment shall be valid for all future treatments related to this healthcare condition.

**Attendance and Cancellation Policy:** In order for Psychology Specialists to provide timely service to all patients, we have implemented the following attendance and cancellation policy.

Effective May 1, 2008, a \$50.00 fee will be assessed to any patient who fails to give timely cancellation of their appointment. A \$50.00 fee will be assessed to any patient who cancels an appointment with less than 24-hour notification. These fees cannot be billed to your insurance and will be billed to you directly.

Thank you for your understanding and assistance.

**Methods of Payment:** Credit Card, Cash, Personal Checks and Money Orders. There will be a \$25 NSF charge for any returned checks.

The patient/guarantor is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional fees.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insured or Guarantor (if patient is under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

# Authorization for Release of Information

PLEASE PRINT OR TYPE:

Authorization is given to:

**Psychology Specialists**

To Release to and Exchange with:

_____	_____
_____	_____
_____	_____

Information on:

\_\_\_\_\_ **Patient Name**

\_\_\_\_\_ **Patient Date of Birth**

For the purpose of continuity of care/exchange of information, I authorize the release of any and all medical records regarding my treatment including:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Face Sheet         | <input type="checkbox"/> Medical record           | <input type="checkbox"/> Progress Notes                                 |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Admission Record         | <input checked="" type="checkbox"/> All Information Regarding Treatment |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Social History           | <input type="checkbox"/> Other _____                                    |
| <input type="checkbox"/> Consultation       | <input type="checkbox"/> Psychological Evaluation |   |
| <input type="checkbox"/> Laboratory         | <input type="checkbox"/> Summary of Care          |   |
| <input type="checkbox"/> X-ray              | <input type="checkbox"/> Treatment Plan           |   |

I understand that I have the right to read and/or copy the information to be disclosed for the required fee. I also understand that I have the right to revoke this consent by written statement at any time; otherwise it will automatically expire one year from the date of authorization. Information released prior to any revocation is not affected. I understand that the consequences of refusing to sign this form are: Information will not be released.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If not signed by the patient, specify relationship to recipient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Signature Verified by: \_\_\_\_\_ Witnessed \_\_\_\_\_ Comparison

Recipient I.D. Verified by: \_\_\_\_\_ Driver's License # \_\_\_\_\_ Other

Date Released: \_\_\_\_\_

Released by: \_\_\_\_\_

**NOTICE TO RECEIVING AGENCY/PERSON:** Under the provision of the Illinois Mental Health and Development Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.