Susan LaFreniere & Associates

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Client Intake & Billing Information

Client's Legal Name: _____ Date: _____ Case #: _____ DX: _____

Gender: _____ F ___ M Date of Birth: _____ SS#: _____

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

Home Phone: _____ Work: _____ Cell: _____

May we identify ourselves when we call or leave messages? Yes No _____

Email: _____ Employer: _____

Marital Status: S M D W Spouse's Name: _____ Date of Birth: _____

Name of Referral Source: _____ May I thank them? Yes No

In Case of Emergency Notify: _____ Phone(s): _____

Primary Concern: _____

Primary Insurance Information

Insurance: _____ Card #: _____

Policy Holder Name: _____ Date of Birth: _____

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

Phone: _____ Employer: _____ Relationship to Client: _____

We need to make a copy of your ins. card(s) to obtain benefit & billing information on your account. Thank you.

Secondary Insurance Information

Insurance: _____ Card #: _____

Policy Holder Name: _____ Date of Birth: _____

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

Phone: _____ Employer: _____ Relationship to Client: _____

Office Policies & Procedures Agreement

I understand that I am requesting counseling, psychotherapy, and/or related services from _____
Therapist's Name

and that such services will be provided under the terms of the following agreement. In particular, I acknowledge that all charges accruing from such services are my responsibility.

As used in the agreement, "Therapist" is (named above), and I am identified as the "client." Although I am identified as the client, I may not be the only person receiving services directly from the Therapist. If the client is a minor, all references identifying "client" apply to the financially responsible party.

Appointments: Sessions are normally 53-60 minutes in length.

Cancellation/No Show: *Cancellations must be made 24 hours in advance.* Less than 24-hours notice will result in the client (not insurance) being responsible for the full cost of the session if the time slot cannot be filled.

Fees: ***Fees are due at the time of service*** unless other arrangements are made with the office manager or therapist and may be paid by check, cash or credit card. *If client chooses to participate in a group, this is a committed, guaranteed placement, therefore, client will be billed regardless of attendance.* Client may be charged for professional time not covered by insurance (NCBI). Examples of this include: Sessions exceed 75 minutes, multiple sessions on the same day and/or therapist consults with other professionals on client's behalf. The fee schedule is reviewed and updated yearly

at the beginning of the year. Persons for whom the fee represents an obstacle to treatment are encouraged to discuss this with the Therapist.

Insurance: This office will bill the client's insurance carrier as sessions occur. Billing is the responsibility of the client and is offered as a service only. This office assumes no responsibility or liability for performing this service or for the actions of the insurance carrier. The billing of secondary insurance (if applicable) through our office is dependent upon receipt of the Estimation of Benefits paperwork from the primary insurance. Usually, these will come to the office. If they do not, it is client's responsibility to provide them in a timely manner. If there is a remaining balance once the secondary insurance has paid (or secondary has not paid within 3 months), this balance is the responsibility of the client and is in addition to their standard co-pay amount.
Client understands that client (or financially responsible party) is responsible for all charges, regardless of the actions of client's insurance carrier or misquotation of benefits. Any assistance by the office manager or Therapist in helping the client to obtain benefits in no way constitutes a waiver by the Therapist of any portion of the fees charged. **It is the responsibility of the client to notify this office immediately of any changes to insurance eligibility, coverage, termination, change in carriers, change in address/phone, etc.**

Past Due Accounts: Accounts where the agreed upon payment has not been received for 30 days or more are considered past due. Past due accounts are subject to:

- Per month billing service fee – $12.50 or current fee at time of billing
- Accrued interest of 1.5% / month, 18% annually
- Be forwarded to collections/small claims legal processing
- An additional 35% - 50% of the unpaid balance added to the account to cover collection expenses

If any action is brought to enforce this agreement, the Therapist shall be entitled to attorney fees and costs if they are the prevailing party. In addition, the Therapist shall be entitled to reimbursement for reasonable expenses in attempting to collect unpaid fees.

The client may terminate the services of the Therapist at any time. The Therapist retains the right to terminate any obligations to the client to provide continuing treatment by giving the client seven (7) days notice of intent to do so. The Therapist may use professional discretion and elect to refer the client elsewhere as the Therapist sees fit.

The Therapist shall have no other obligations to the client and the Therapist's professional liability shall be limited only to acts which depart from the usual professional practices where acceptable standards are not followed and due care is not exercised.

If you have any questions, please don't hesitate to ask. Thank you for your cooperation.

I give permission for my therapist to discuss my case as necessary with other professional staff working as part of Susan LaFreniere & Associates for the purpose of coordinating care for myself, loved ones and/or family members.

Yes No

By signing below, both client and/or responsible party acknowledge that they have read, understand, and agree to the policies and procedures as outlined above and have read the Privacy of Information Policy (a copy of this policy is available upon request.) For direct billing to client's insurance company, client/responsible party authorizes release of all records required, including those related to substance abuse, and request payment of benefits be made on client's behalf to _____.
Therapist's Name

Date: _____ **Client Signature:** _____ 

Is the client the financially responsible party? Yes No If No, the following information is needed:

Responsible Party Signature: _____ **Printed Name:** _____

Complete the information below for the **responsible party** if **different** from client, otherwise circle: **same**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work:** _____ **Cell:** _____