PC Psychotherapy
50 S. Main St. Suite 200
Naperville, IL 60540
P: 630-315-9155
F: 630-352-2301

Additional Location
10 Saravanos Dr.
Yorkville, IL 60560
P: 630-315-9155
F: 630-352-2301

PC Therapy New Client Intake Paperwork

Patient Name: _____ Date of Birth: _____

Social Security Number (for billing purposes): _____

Member or Parent Name: _____ Phone Number: _____

Address: _____

Email Address: _____

Insurance Carrier: _____

Policy Holder: _____ Date of Birth: _____

Policy Holder's Social Security Number (for billing purposes): _____

Member ID: _____ Group Number: _____

Policy Holder's Address and Phone if different from client's contact information:

_____

_____

Client's current medication list: _____

_____

Type to enter text

WELCOME TO PC THERAPY

We appreciate you choosing PC Therapy to meet your needs at this time. We ask that you please read the following closely as it explains pertinent information regarding our clinical policies.

Client Policies and General Information

Appointments ~

If you are unable to keep your appointment or are going to be late, please contact your therapist or the main office as soon as possible. This courtesy allows us to make the time available to other clients. A fee of $75 for a 50min session can be applied to your account for missed appointments or cancellations without 24-hour advice notice. Messages may be left on our voice mail at anytime.

Contacting Your Therapist ~

In the event of an emergency, please call 911 or go to your local emergency room. For non-emergency needs, you may leave a message for your therapist at his or her voice mail. Please note that your therapist will not usually accept phone calls while with a client.

Time spent with you on the telephone by your doctor/therapist other than for appointment or medication questions may be charged at a rate of $25 for five minutes and $50 for ten minutes and over.

Confidentiality ~

PC Psychotherapy complies with those standards set forth by HIPAA. All information regarding our clients is considered strictly confidential and will not be given to anyone. However there are exceptions, including those situations which we are required by law to report such as, suspected abuse to an individual (child and/or adult); harm or threat to self or others. While these situations are rare, you should be aware of the possible occurrence as well as the protective actions required by your therapist. These actions may include, notifying the potential victim, notifying the police, seeking appropriate hospitalization for the client, and/or contacting family members or others who can help provide protection.

In keeping with generally accepted procedures in the mental health field, clients are not normally given access to their chart or chart notes. In the event of a request for the transfer of records to a new therapist or doctor, the records will be forwarded directly to that person upon completion of a release of information form by the client, and a fee may be charged.

Termination~

Termination of treatment is best done on the basis of a mutually agreed upon, face-to-face interaction with your doctor or therapist.

PC Therapy Financial Fees & Policies

Please understand that payment of your bill is part of your treatment and care. The following is a statement of Financial Policy, which we require all of our parties to read, understand, and sign prior to treatment.

When Payment is Due~

Payment is due at the time services are rendered in the office unless prior arrangements have been made with the business office. In order for our clinic to offer you our highest quality of services, all balances over 60-days and/or any account that reaches a balance of $300 must be paid in full before you are able to schedule future appointments.

If charges are unpaid after 90 days, your account may be turned over to a collection agency with any information they may require for collection of said debt. Should your delinquent account be turned over to a collection agency or attorney, please be advised that you will be responsible for court costs, attorney fees and collection fees.

Court Cases ~

PC Psychotherapy does not typically become involved in any custody, visitation, or legal disputes. However, if PC Psychotherapy does become involved in any legal activity, it will be billed to the client at the rate of $175.00 per hour. If the therapist is mandated to have any court appearance, there will be a base fee of $250.00 in addition to the $175.00 per hour rate. PC Psychotherapy also reserves the right to impose additional charges as necessary with or without warning.

Divorce Situations & Payment ~

We look to the adult who initiated treatment on behalf of the child to assume responsibility for payment, regardless of divorce decree documentation. As well as we may ask for you to provide a copy of the divorce decree. We expect the parents to work out payment arrangements between themselves.

Insurance ~

We accept assignment of insurance benefits if we have a management contract with your insurance company. This will be verified at your first appointment. If we accept your insurance, you are responsible for co-pays, contract deductibles and any amount not paid by your insurance e with the exception of provider contracted reductions.

The patient is solely responsible for obtaining the necessary authorization from their insurance affiliate before their first appointment and agrees to pay said appointment fee in full if it is later determined authorization was needed. Please cooperate with our staff in providing this information.

In the event an authorization is issued but the insurance company refuses to pay for the services, the balance due will be your responsibility.

Clinical Fees~

The following is a notification of our fees for all services not covered by insurance. These fees will allow us to accommodate our clients' requests for non-covered services such as medical records and the high volume of letters to insurance companies, employers, schools, etc. Every device we provide has an associated overhead expense, and we must cover these costs.

It is the client;;s responsibility to understand what services their insurance company covers. You may refer to your benefit manual or call the member services number on the back of your insurance card if you need further clarification.

We remain committed to providing you the highest quality of care. Thank you for your understanding.

No Show and Late Cancellation fee	$75	Dictated letter (more than 2 pages)	$40
Disability forms	$25	Extended phone calls	$50
Worker's Comp. forms	$25	Returned (NSF) check fee	$40
School/Work forms	$25	Dictated Letter (1-2 pages)	$25

Statements of Understanding

I have read, understand and agree to the above clinical and financial policies. I hereby agree to assign to my doctor/ therapist the medical benefits to which I and/or my dependent are entitled to under any health insurance plan. I give my consent to my doctor/therapist to provide evaluation, treatment and/or other services that we may mutually determine to be appropriate. I am participating in treatment voluntarily and I understand that I have the right to refuse or discontinue treatment at any time. I have had the opportunity to discuss my reasons for seeking services and I understand my responsibilities in this therapeutic relationship.

X Client Signature: _____ Date: _____
(12 years of age or older)

Parent/Guardian Signature: _____ Date: _____
(Necessary for clients under the age of 18)

Print Name _____

X Signature of Responsible Party_____
(Person Responsible for payment)

Print Name_____

Address (if different from client**)**_____

_____

Phone (if different from the patient) Home_____ Cell_____

Credit Card Authorization Form

PC Psychotherapy requires that all patients have a credit card on file. This conveniently assists in the collection of patient responsibilities at the time of service and minimizes the need for other billing. Account numbers are kept secure. At any given visit you may choose to pay by cash, or check, or defer to the credit card on file. You may also revoke this agreement in writing at any time. Your cooperation is much appreciated.

Credit Card Information: Please be sure to complete all sections.

1) Card Holders Name: _____

2) Credit Card Number: _____

3) Expiration Date: _____

4) 3 Digit Security Code on back of card (4 digits on front of AmEx): _____

5) Billing Zip Code of Credit Card: _____

4) Type of Card: Visa, MasterCard, AmEx, Discover, Flex spending

5) Card Holders' Signature: _____Date: _____

6) Card Holder Phone number: _____

_____(initial) I understand that by signing above, I am authorizing PC Psychotherapy to charge my credit card for balances 90 days past due. These balances may include unpaid co-pays, co-insurance amounts, deductibles, and/or charges for missed/late cancelled appointments. I understand that PC Psychotherapy can provide me a statement as well as a receipt for any charges that are applied to the credit card upon request. PC Psychotherapy will contact me if my card is declined or expired should I fail to update this information.

_____

Client Signature (12 and over) Date

_____

Guardian Signature (if applicable) Date

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