ALDRICH
COUNSELING SERVICES

Dx Codes: _____(Provider Only) William Aldrich Ed.S., LSPE, LPC

CLIENT INFORMATION

Client Name: _____ Gender: _____ Date of Birth: _____

Social Security #: _____ Marital Status: S / M / D / W Student: Y / N

Race Circle: American Indian or Alaskan Native / Asian / African American / Caucasian / Pacific Islander / Other / Declined

Ethnicity Circle: Hispanic / Non Hispanic / Declined Language: _____

Street Address: _____

City: _____State: _____ Zip Code (9 digits): _____

Email Address: _____ _____ Ok to send e-mail

Home Phone: _____ Work #:_____ Cell #:_____

_____ Home: OK to leave message _____Work: OK to leave message _____Cell: OK to leave message

Employer: _____ Occupation: _____

Work Address: _____

Person Responsible for Payment: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____

Address (if different):_____

Home Phone: _____ Work #: _____ Cell #:_____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work #: _____ Cell #: _____

Referred by: _____

Primary Care Physician: _____ Phone #: _____

Address: _____

→ → To file insurance I must have the following information:

Primary Insurance

Insurance Company Name _____ Phone: _____

Name of Insured: _____ Employer: _____

Social Security #: _____ Date of Birth: _____

Policy #: _____ Group #:_____Effective Date: _____

Secondary Insurance

Insurance Company Name _____ Phone: _____

Name of Insured: _____ Employer: _____

Social Security #: _____ Date of Birth: _____

Policy # _____ Group #: _____Effective Date: _____

→ → PLEASE READ & COMPLETE THE BACK OF THIS SHEET

PAYMENT/INSURANCE AGREEMENT & AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

Agreement to Pay. I agree to pay fees/co-payments for service at the time of each visit. I understand that I am personally responsible for payment of all charges. If the patient has coverage under a managed health plan (HMO, PPO etc.) to which I subscribe and in which the provider is a participating provider, I am responsible for the co-payment as determined by the insurance plan. I understand that the provider will file insurance as a courtesy; however this does not release me of my responsibility for payment of the charges for services. I am responsible for payment even if a divorce settlement dictates that medical bills are to be paid by a former spouse. Appropriate documentation will be provided with which reimbursement may be sought from the ex-spouse. I understand that delinquent balances are subject to collection procedures and I am responsible for any collection agency or court fees. If the provider must utilize a collection agency to collect on a delinquent account, such action could require that the provider release to the collection agency, attorneys and/or the court information including but not limited to the identities of the parties involved, the dates and nature of the charges, and any other information contained on any claim filed.

Fee Schedule. The usual and customary fee for services is $130. In addition to weekly appointments, there may be a charge for other services such as record review, report writing, telephone conversations longer than 5 minutes, requested attendance at meetings/consultations with other professionals, or preparation of treatment summaries. These are charged on a prorated basis. These costs are typically not covered by insurance.

Missed appointments. I understand that once I have made an appointment, the time is reserved just for me. Insurance does not reimburse for missed appointments and I will be fully responsible for this fee. Therefore, **I understand and agree that I will be charged $130 and required to pay for missed appointments not canceled 24 hours in advance.**

Legal Services. If I am here for that purpose, I will discuss this with the therapist ahead of time and discuss fees for such services. Insurance also does not typically cover services performed for legal purposes, such as custody evaluation etc. I understand that I will be expected to pay for professional time required even if the provider is compelled to testify by another party. If I am here as a result of a court order, I understand that this is an agreement between me and the courts, not the therapist, and I am responsible for payment of all charges. Because of the complexity and difficulty of legal involvement, the fee is $350/hour (2 hr. minimum) for preparation for and attendance at any legal proceeding.

Insurance Reimbursement. I understand that I am responsible for knowing exactly what health care services my insurance plan covers and securing any pre-certification that my insurance may require for reimbursement. Payment for any charges denied or not covered by my insurance company becomes my responsibility and I agree to pay these charges. "Managed Health Care Plans" such as HMOs and PPOs often require advance authorization before they will provide reimbursement for health care services. I understand that securing benefits under health insurance or other health plans will require the provider provide the plan management with confidential patient information including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the provider to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the patient. I also understand that I have the right to pay for services myself and avoid the complexities of filing insurance all together. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

Insurance to be filed by (circle one): William Aldrich Ed.S., LSPE, LPC Client Neither

By signing below, I authorize William Aldrich Ed.S., LSPE, LPC to file insurance claims and to pay William Aldrich Ed.S., LSPE, LPC directly. I authorize payment of medical benefits to William Aldrich Ed.S., LSPE, LPC by my insurance company. By signing below, I also acknowledge that I have read, understand, and agree to the above information.

_____ _____

Signature of patient, parent or legal guardian Date

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