POTOMAC PSYCHOLOGICAL CENTER, LLC

PATIENT INFORMATION (PLEASE PRINT):

Full Name _____
Last First MI

Home Address _____

City, State, Zip _____

PRIMARY Phone number _____Other Phone #_____

Work Phone_____ **Email:**_____

*****Please note that we will leave general voicemail messages on the numbers provided. These messages will NOT include any personal health information. Please ask the front desk if you still would not like any messages left*****

Male _____Female_____ Birth Date _____ Social Security#_____

Marital Status: Single_____ Married _____ Separated_____ Divorced_____ Other _____

Employer _____ Job Title _____

Emergency Contact _____ Phone _____Relation_____

Referred by_____ Are you the policy holder for your insurance? Y or N

SUBSCRIBER INFORMATION (if different from the patient)

Full Name _____
Last First MI

Relationship to Patient: Mother _____ Father _____ Other _____

Custody Status: Legal _____ Physical_____

Home Address _____

City, State, Zip _____

Home Phone _____Cell Phone_____Work Phone_____

Birth Date _____Social Security #_____ Male _____ Female _____

Marital Status: Single_____ Married _____ Separated_____ Divorced_____ Other _____

Email: _____

OTHER PARENT / GUARDIAN INFORMATION (Required if patient is under 18 yrs): ***This information is required for both parents.

Full Name _____
Last First MI

Relationship to Patient: Mother _____ Father _____ Other _____

Custody Status: Legal _____ Physical: _____

Home Address _____

City, State, Zip _____

Home Phone _____Cell Phone_____Work Phone_____

Birth Date _____Social Security #_____ Male _____ Female _____

Marital Status: Single_____ Married _____ Separated_____ Divorced_____ Other _____

Email: _____

PRIMARY CARE PHYSICIAN INFORMATION:

PCP/Pediatrician/Etc.: _____
NAME
Office Phone: _____ Fax (if known) _____

Informed Consent for Treatment

I, _____ (name of patient), agree and consent to participate in behavioral health care services offered at and provided by Potomac Psychological Center, LLC, behavioral health care providers. I understand that I am consenting and agreeing only to those services that the provider is qualified to provide within: (1) the scope of the provider's license, certification, and training: or (2) the scope of the license, certification and training of the behavioral health care provider directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment, and I am legally authorized to initiate and consent to treatment on behalf of this individual.

Cancellation Policy

All appointments must be canceled by 3:00 p.m. the business day (Monday- Friday) before my scheduled appointment. Failure to do so will result in a missed appointment charge of **$75** for therapists and **$75** for psychiatrists (M.D.) and psychologists (PsyD.). If I arrive 20 or more minutes late to my therapist's appointment, I may be charged for a missed appointment. In the event of **snow or inclement weather, my appointment can be canceled the same day with no charge, ONLY IF Loudoun County Government (not the school system) is closed AND ONLY IF I call to cancel my appointment prior to the appointment time.** Anytime I properly cancel an appointment I can ask for a cancellation number from a PPC employee. If there is any question about a cancellation, I understand that I may be inquired to provide the cancellation number. In case you have to leave a message with the cancellation request, you WILL receive a return phone call. If you do not receive a return call, PLEASE call again since we may not have gotten your message. By signing this form, I acknowledge that I have read and fully understand the PPC policy for cancellation of appointments. X_____ (Please initial)
Note: **The PPC office does not make appointment reminder calls**

Missed Appointments

If the missed appointment/late cancel is due to a medical emergency, family emergency, transportation issue such as mechanical problems, or you believe the appointment was scheduled in error, you will need to fill out an appeal form **within 60 days** of the missed appointment date and provide a doctor's receipt, or any other supporting documentation. We are not obligated to accept appeals after the 60 day mark.
X_____ (Please initial)

Release, Assignment, and Financial Responsibility

- I accept financial responsibility for all clinical and administrative services provided by Potomac Psychological Center, LLC. I acknowledge being informed that my insurance may not cover all services requested. When a denial of payment is received from my insurance carrier the charge will become my responsibility. My financial responsibility explicitly includes, but is not limited to, initial evaluations, medication management, individual therapy, marriage counseling, couples counseling, group therapy, assessments, psychological testing, professional fees, forensic fees, legal fees, or collection fees if my account goes to a third party.

- I authorize the release of any medical, mental health, or other information necessary to process a claim with my insurance carrier. I authorize payment to Potomac Psychological Center, LLC for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

- In many cases, there is a need for us to exchange information with other parties, such as other treating physicians. If you do NOT wish to give us permission or have any doubts about granting this permission at this point to exchange information with other physicians, please cross out this paragraph. If you cross out this paragraph, we will ask you to sign separate release of information forms when and where appropriate.

- Ancillary services, include, but are not limited to, writing a letter (i.e., for school), phone calls (i.e., to schools, to other providers), or writing a recommendation. The fees are billed as follows: Psychiatrists bill at an hourly rate of $200.00 per hour, psychologists $175/h, and master's level clinicians $150/h.

- Legal services (i.e., court appearance, conveying information to court, letter to an attorney) are billed at a rate of $350 per hour for psychiatrists, $300/h for psychologists and $250/h for master's level licensed clinicians.

- There will be a $15 charge for any emergency prescriptions, or other convenience oriented care rendered. Please be advised this office does not respond to automatic refills pharmacy requests. It is the patient's responsibility to submit the written prescriptions to the pharmacy. No medication change will be made over the phone.

- In order to maintain a calm and pleasant atmosphere in the waiting room, cell phone use is prohibited.

PPC Policies Pertinent To Payments and Your Insurance

- Initial Evaluation and Diagnosis: 45 minutes, $290 for psychiatrist, $250 doctorate level, $150 for master's level clinician
- Subsequent Counseling Sessions: 45 minutes, $160 for doctorate level, $110 for master's level clinician
- Medication Management Follow-Ups: 10-15 minutes, $115 for psychiatrist
- Marriage and Family Sessions: 45 minutes, $175 for doctorate level, $125 for master's level clinician

- Please be advised that you are fully responsible for the accuracy and timeliness of your insurance coverage. You acknowledge that if your insurance **requires** a referral or an authorization, you are responsible for obtaining that in order for your claims to be paid. By signing this agreement you agree to fully compensate Potomac Psychological Center, LLC for all fees not reimbursed by your insurance company. We do not file claims with secondary insurance companies.

- Payments for services, including co-payment and deductible amounts, are **due at the time of services,** unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard and Visa. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. X_____ (Please initial)

- **Returned checks will result in a $35 fee that will be posted to your account.** Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. PPC is a partner in the Loudoun County Commonwealth Attorney's check enforcement program. X_____(Please initial)

Insurance Procedure

- You are responsible for updating your personal and insurance information periodically, which includes providing our office with copies of your insurance card and driver's license. We will submit fees for your

covered medical services to your insurance company; however we expect payment of all services rendered within 60 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. PPC will make a "good faith" effort to file and collect from your insurance company, but you will be responsible for any services not paid by your insurance. X_____ (Please initial)

- I understand that PPC is not obligated to make any "insurance adjustments" after 120 days from the date of service. X_____ (Please initial)

- We are not liable for any refunds that may occur as a result of your not advising us of any change in your insurance coverage or insurance company. To clarify, if your insurance coverage or your insurance carrier changes and you do not notify PPC within 30 days of that change, PPC reserves the right to NOT issue a refund related to those changes and not refund money collected during that time period. X_____(Please initial)

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.
Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered. X_____ (Please initial)

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us **promptly** for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. Accounts that are delinquent with NO payment within a 60-90 day time are subject to be outsourced to a collection agency. PLEASE contact us to set up a payment plan in cases where you will need to make consistent payments to address a large balance

Thank you.
My signature below constitutes acknowledgement and acceptance of these policies.

_____ _____

Print Patient Name Signature of Patient or Guardian Date

I have read and understand Potomac Psychological Center, LLC
Notice of Privacy Practices Sheets (attached to clipboard)

_____ _____

Print Patient Name Signature of Patient or Guardian Date