ViewPoint
Psychological Services

New Client Information

Clients Name: _____ Date Of Birth: _____

Clients Address: _____

City: _____ State: _____ Zip Code: _____

Phone:
Home: _____ Work: _____ Cell: _____

Email Address: _____

Cell phone carrier (AT&T, Verizon etc.) for text reminders: _____

IMPORTANT: DO NOT rely solely on text and/or email reminders. Text and email reminders are being offered as a courtesy only, it is ultimately the client and/or guardians responsibility to keep track of appointment dates and times.

Allergies to Medications or Environment: _____

Primary Care Physician: _____

Phone number of Physician: _____

Name of Legal Guardian: _____

Insurance Information:
Name of Primary Individual on Insurance Policy: _____

Date of Birth of Primary Individual on Insurance Policy: _____

Relationship to client: _____

I, _____ , am hereby providing authorization for the professionals and support staff of Viewpoint Psychological Services to release any required information to the designated insurance company and the listed Primary Care Physician. I understand that I am responsible for any cost not covered by the insurance for the services I or my dependent receives from this office.

_____ _____

Signature of Client or Legal Guardian Date

Viewpoint Psychological Services Policies

Please take a few moments to review the policies of Viewpoint Psychological Services. We have created these policies so that we can maintain consistency and inform clients of various situations at the onset of treatment. **Please initial each policy indicating that you have read and understand the policy.** ***(if you have a question regarding any of the following policies please see a member of the office staff who will be happy to explain any questions you may have).***

PLEASE INITIAL EACH POLICY

_____**Policy A: MISSED APPOINTMENT/LATE CANCELLATIONS.** Your appointment time is reserved exclusively for you. If you fail to show up for a scheduled appointment OR if you do not provide 24 HOURS NOTICE, you will be charged **$ 70 per missed appointment or late cancellation**. ***Please note: For appointments scheduled for Monday you must notify the office prior to 5:00 pm on Friday to cancel.***

_____**Policy B: Insurance Changes.** Clients are responsible for monitoring their own insurance benefits, such as co-pays, deductibles, insurance limits, etc. Clients agree to notify Viewpoint whenever there is a change in insurance. If the client fails to do so and the service is not covered, the client assumes all financial responsibility. Payment is due at the time of service, and upon receipt of a bill.

_____**Policy C: Consent to Provide Treatment.** I hereby provide my consent to Viewpoint Psychological Services to provide psychological, counseling, and/or consulting services to me or my dependent. I verify that I have the right to provide such consent. I understand that I can withdraw my consent at any time with the provision of such in writing to the treatment provider (s). This consent will remain in effect until such time as I revoke it.

_____**Policy D: No Smoking.** We strive to provide a healthy and clean environment for all clients and employees of Viewpoint Psychological Services. For this reason, no smoking is permitted within the office, waiting are, parking lot, or outside the building.

_____ **Policy E: Child Supervision.** I understand that Viewpoint psychological Services cannot accept responsibility for unattended children. It is the responsibility of the parent/caregiver to arrange for proper supervision.

_____ **Policy F: Termination of Treatment.** Viewpoint Psychological Services maintains the right to terminate treatment for any reason at anytime, including-but not limited to -verbal or physical abuse to any staff or clients of Viewpoint Psychological Services, physical assault or threat to assault any staff or other clients, or refusal to comply with essential treatment recommendations that could result in harm to self or others.

Client/Legal Guardian Signature: I have read each of these polices and I realize that I am responsible for informing and making sure that anyone who accompanies me to the office also complies with these policies. By initialing each policy, I am indicating my agreement to follow them, without deviation. I am also acknowledging that I have been provided with a copy of the privacy policies of Viewpoint Psychological Services.

Signature of Client/Guardian Responsible: _____

Printed Name: _____ Date: _____

Relationship to Client: _____

____ INITIAL HERE IF IS THIS DOES NOT APPLY TO CLIENT

Viewpoint Psychological Services
Divorced/Soon to be Divorced/Separated Parent Policy

The professionals and employees of Viewpoint Psychological Services seek to provide a high quality of care to our clients and their families. Divorce can intrude on or complicate the services being provided. The following is our policy regarding Divorced- Soon to be Divorced or Separated Parents:

1. We need a copy of the custody agreement or order at your child's first appointment.

2. Court- related evaluations require a court order.

3. We require that the parent requesting treatment and/or evaluation through our office notify the other parent (birth or adoptive) that treatment is being sought.

4. We ask that both parents schedule an appointment to provide important information regarding the child and to receive periodic treatment updates. Exceptions may be made on an individual basis with legally-bound reasons being provided (ex. Potential for danger, etc.). It is the responsibility of the treatment-seeking party to request consent from the other parent. If we are informed that a parent with decision-making rights does not consent to treatment, we will not continue to provide services.

5. **Our office does not accept responsibility for seeking payment from the non-treatment seeking parent, regardless of your arrangement.** The following are the options for payment of services: **a)** both parents can sign the **New Client Packet** in full and divide cost and pay together at the time of service, or **b)** the treatment- seeking parent is responsible for paying for the services and gaining reimbursement from the other party. Either option requires that monies due be paid at each appointment, or in advance.

6. We do not agree to keep information provided by one parent from the other parent, if you share joint legal custody. Information important to the well-being of the child will be openly shared and discussed. Step-parents may be asked to participate in evaluation and treatment where appropriate. This is in addition to the limits of the confidentiality policy provided.

I, _____(parent or legal guardian). Have read the divorce policy provided. I understand the policy and agree to its terms and provisions. I provide my consent from the provider(s) to speak to my child(ren)'s other parent and related parties regarding the treatment and/or evaluation provided.

_____

Signature Date

Viewpoint Psychological Services
Financial Policy

Please read each policy. If you have any questions please see a member of the office staff who can help answer any questions.

T*hank you for choosing Viewpoint Psychological Services. We are committed to your treatment being successful.* ***Please understand that payment of your bill is considered part of your treatment.*** *This is a financial responsibility on your part that obligates you to ensure full payment of your bill. Prompt payment allows us to control cost and continue to deliver effective services Therefore, all clients will be required to establish financial arrangements for payment of their account. All clients must complete our client information and insurance form before they see a provider. As a courtesy, we will verify your mental health coverage and bill your insurance company on your behalf. We cannot be held responsible for any inaccurate benefit information that is given to us in any form, whether it be by phone, fax, email or online. Also, we cannot be held responsible for any omission of benefit information, such as mental health benefits being covered through a different insurance company than what is shown on your insurance card.* ***You are ultimately responsible for the payment of your bill. Your insurance policy is a contract between you and your insurance company.***

Regarding Your Insurance

- W***e require your co-payment at the time services are rendered.*** It is your responsibility to know your benefits. We are not a party to that contract or changes within that contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc. other than to supply factual information as necessary. If you receive payment from the insurance company for services rendered by Viewpoint Psychological Services you must reimburse Viewpoint Psychological Services in full at the time of receipt of such payment. If you have secondary insurance we will provide you with a statement for you to submit to your secondary insurance company. **We will not bill your secondary insurance company**. The client agrees that if he or she defaults on any balance owed to Viewpoint Psychological Services and it becomes necessary for Viewpoint Psychological Services to engage the services of an attorney, collection agency or other lawful method of collection, the client will pay the original balance owed and reimburse Viewpoint Psychological Services for all cost incurred by the collection of said debt.

Regarding Your Deductible

- ***If you have a deductible and Viewpoint Psychological Services is considered "in network" with your insurance company we require payment of services at the time of treatment***. Because we are in-network with your insurance company, we know in advance the "allowed amount" of services rendered. We accept the allowed amount from your insurance company. **If you have met your deductible or maximum out of pocket amount you must bring proof of this from your insurance company to your appointment.** If you do not supply this information to Viewpoint Psychological Services you will be responsible for payment at the time services are rendered. If we are considered "out-of-network" with your insurance company you are responsible for full payment at the time services are rendered.

Regarding Insurance Billing

- We will bill your primary insurance company as a courtesy to you. However, you are ultimately responsible for payment of your bill. We will bill your insurance carrier no fewer than two times to ensure payment of your benefit for services rendered by Viewpoint Psychological Services, However, in the event that repeated billing of your insurance company does not satisfy your balance for services rendered, we will have no choice but to look to you for full settlement of your account. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT. If paying by check you understand and authorize all dishonored checks plus a processing fee with applicable taxes to be charged to your account.

Missed Appointments and Late Cancellations

1. **Your appointment time is reserved exclusively for you. Therefore, our policy is to *charge $ 70.00 for missed appointments, unless you cancel the appointment <u>at least 24 hours in advance</u>. If your appointment is scheduled for Monday you must call before 5:00 pm on Friday in order to allow us time to fill the appointment.**

* *This charge will be billed to you directly, not through your insurance company. A fee of 2% of the total balance will be assessed on all unpaid balances, including missed appointment and late cancellation fees.*

After Hour Appointments

- **<u>Our normal business hours are from 9:00 A.M. To 5:00 P.M</u>**. ***Appointments that are scheduled outside of normal business hours, when office staff is not available to collect your payment, must be made by either check or cash with exact change.*** This payment will be collected by your provider. Credit card payments or payments that require change be given will not be accepted after hours. **If you need to make your payment on a credit card you may call the office prior to your appointment during business hours and make payment with your credit card. If you need a receipt for your payment, it will be mailed to you the next business day.**

Minors – **The adult accompanying the minor is responsible for payment. W**e do not get involved in custody or other financial arrangements between parents. We will provide a receipt so you can collect from another party, if needed.

I have read the above Financial Policy and understand that regardless of insurance status I am ultimately responsible for the balance of my account for any professional services rendered by Viewpoint Psychological Services.

Client's Name: _____ Date of Birth: _____

Clients Signature or Responsible Party: _____

Legal Guardian (if applicable): _____