Green House Group, PA

CLIENT FIRST NAME _____ PRIMARY PHONE _____
Ok to leave message? Y N

CLIENT LAST NAME _____ SECONDARY PHONE _____
Ok to leave message? Y N

STREET ADDRESS _____ EMAIL _____
(Optional)

CITY, STATE, ZIP _____ DATE OF BIRTH _____
(Required)

Male_____ Female_____ Other_____ Married_____ Single_____ SOC SEC #_____-_____ -_____

PARENT NAME (if minor client)_____ PARENT PHONE _____
Ok to leave message? Y N

EMERGENCY CONTACT (name) _____ PHONE _____

IS CLIENT RESPONSIBLE FOR BILL? Y N If NO, list responsible party (parent or guardian) below:

RESPONSIBLE PARTY # 1 BILLING ADDRESS (If different from above)

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

RESPONSIBLE FOR _____ % OF BILL

RESPONSIBLE PARTY # 2 BILLING ADDRESS

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

RESPONSIBLE FOR _____ % OF BILL

INSURANCE INFORMATION

Must be completed in addition to copy of insurance card(s)

PRIMARY INSURANCE COMPANY NAME _____

I.D. # _____ POLICY # _____ GROUP # _____

CLIENT'S RELATION TO INSURED SELF_____ SPOUSE_____ CHILD_____ OTHER_____

POLICY HOLDER NAME _____ DATE OF BIRTH _____
(**Required**, if different from client)

ADDRESS _____ WORK TELEPHONE _____

CITY, STATE, ZIP _____ HOME TELEPHONE _____

EMPLOYER _____ SS # OF POLICY HOLDER _____

CLARIFY THE FOLLOWING INFORMATION WITH THE *PRIMARY* INSURANCE COMPANY:

IS CLINICIAN COVERED BY PLAN? Y N

IS A REFERRAL, NOTIFICATION, OR AUTHORIZATION REQUIRED? Y N AUTHORIZATION #_____

WHAT IS THE COPAY/COINSURANCE FOR THIS SERVICE? _____

SECONDARY INSURANCE COMPANY NAME _____

I.D. # _____ POLICY # _____ GROUP # _____

CLIENT'S RELATION TO INSURED _____ SELF _____ SPOUSE _____ CHILD _____ OTHER

POLICY HOLDER NAME _____ DATE OF BIRTH _____
(If different from client)

ADDRESS _____ WORK TELEPHONE _____

CITY, STATE, ZIP _____ HOME TELEPHONE _____

EMPLOYER _____ SS # OF POLICY HOLDER _____

PLEASE COMPLETE OTHER SIDE

CLIENT NAME/DOB: _____

OTHER INFORMATION

WHO REFERRED YOU TO GREEN HOUSE GROUP PA? _____

FAMILY MEMBERS IN YOUR HOME:

NAME	**AGE/DOB**	**RELATIONSHIP**

PRIMARY CARE PHYSICIAN _____ PHONE # _____

PSYCHIATRIC PROVIDER _____ PHONE # _____

LIST ANY HEALTH PROBLEMS FOR WHICH YOU CURRENTLY RECEIVE TREATMENT

_____

MEDICATIONS _____

HAVE YOU HAD PREVIOUS THERAPY? IF SO, WITH WHOM AND WHEN?

_____

I understand that I am responsible for FULL payment for the services rendered; GHG will submit claims to my insurance company as a service to me. I also understand that I am responsible for obtaining pre-authorization from my insurer, billing fees which I might incur, and any late charges on outstanding balances. I am also responsible for collection fees and/or legal fees incurred in settling any outstanding accounts I might have. If I am unable to keep a scheduled appointment and do not give 24 hours notice, I understand that I will be charged directly for that visit; GHG cannot bill insurance for missed appointments. My signature below authorizes the release of any medical information necessary to the insurer of record so to pay insurance claims for services rendered.

I authorize payment of benefits by my insurer to Green House Group, PA for services described on the health insurance claim form.

_____ _____
Signature Date

If I choose to pay for services on my own and without insurance, I agree to pay $ _____ per session as discussed with my provider. If I choose not to use my insurance and pay privately for services, I agree to waive any right to reimbursement from my insurance company.

_____ _____
Signature Date

I am requesting psychological or neuropsychological testing. I understand that I am financially responsible for any remaining balance related to this service after my provider has fulfilled all contractual requirements with the insurer and exhausted all authorized benefits. This remaining balance may include deductibles, co-pays for authorized sessions, and the billed cost for service hours either beyond or not covered by limits of insurance coverage. The evaluator will provide an estimate of these additional costs, if any, before the assessment has begun.

_____ _____
Signature Date

TO BE COMPLETED BY CLINICIAN:

INTAKE DATE _____ PROVIDER _____ DIAGNOSIS _____ Usual CPT CODE _____ FEE _____

AUTH # _____ # VISITS _____ DATE RANGE _____ to _____ COPAY _____