

# THE POLLOCK GROUP

# CLIENT REGISTRATION

8080 Ward Parkway, Suite 230 Kansas City, MO 64114 Phone (816)822-1922 Fax (816)822-2248

## CLIENT INFORMATION

First appointment date \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ LAST NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ EXT: \_\_ CELL ( ) \_\_\_\_\_

Therapist/Office may leave a message at (preferred #): \_\_\_\_\_

May we contact you by E-mail? \_\_\_ Y \_\_\_ N E-mail Address: \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX: \_\_\_ M \_\_\_ F

Referred by: \_\_\_\_\_ May we thank them for referring you? \_\_\_ Y \_\_\_ N

## EMERGENCY CONTACT

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE & ZIP \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

If someone other than the client is responsible for payment of this account, please enter that information below. If the client is a minor child and the parents do not live together, please provide information for both parents.

RELATIONSHIP TO CLIENT: \_\_\_\_\_ CUSTODIAL PARENT? \_\_\_ Y \_\_\_ N

FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ LAST NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Therapist/Office may leave a message at (best contact #): \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

ADDRESS, CITY, STATE, ZIP \_\_\_\_\_

RELATIONSHIP TO CLIENT: \_\_\_\_\_ CUSTODIAL PARENT? \_\_\_ Y \_\_\_ N

FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ LAST NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Therapist/Office may leave a message at (best contact #): \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

ADDRESS, CITY, STATE, ZIP \_\_\_\_\_

### **CONSENT FOR TREATMENT**

I consent to the provision of psychological services for myself or the minor child or dependent named as patient.

SIGNATURE **X** \_\_\_\_\_ DATE \_\_\_\_\_

**HIPAA AGREEMENT:** The Health Insurance Portability and Accountability Act (HIPAA) form has been made available to me.

SIGNATURE **X** \_\_\_\_\_

### **INSURANCE COMPANY INFORMATION**

If you would like us to file claims to your primary insurance company, please complete the information below and allow us to make a photocopy of your current insurance card.

PRIMARY INSURANCE COMPANY \_\_\_\_\_ ID# \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

CLIENT RELATIONSHIP TO INSURED:    \_\_\_Self    \_\_\_Spouse    \_\_\_Child    \_\_\_Other

CLAIMS ADDRESS \_\_\_\_\_

\_\_\_\_\_

### **INSURANCE ASSIGNMENT**

I authorize the release of any medical or other information necessary to process claims filed on my behalf. I authorize payment of medical benefits to my psychologist or the billing service. I also request payment of government benefits to the party who accepts assignment as indicated on the insurance claim form.

SIGNATURE **X** \_\_\_\_\_ DATE \_\_\_\_\_

(I am the insured or custodial parent for the insured)

## FINANCIAL AGREEMENT

CO-PAYMENT - I understand that my co-payment is due at the time of each appointment.

CANCELLATIONS - I understand that I am responsible for paying my therapist's hourly rate if I forget an appointment or do not give 24-hour notice of a cancellation. I also understand that my insurance does not cover such charges.

PHONE CONSULTATION - I understand that I will be charged my therapist's hourly rate for phone consultations.

ELECTRONIC COMMUNICATION - I understand that insurance will not cover electronic communications at this time.

INSURANCE FILING - I understand that if my insurance company has not paid for services rendered within 60 days, it will be my responsibility to pay for such services and to follow up with my insurance company for reimbursement. If my account is more than 90 days delinquent, it will be turned over to a collection agency, unless I make an acceptable agreement with my therapist. Our office and your therapist cannot assume responsibility for interpreting your insurance policy or for your specific insurance coverage.

Your signature below indicates your understanding of, and agreement with, the policies outlined above, and your agreement to pay your therapist for services rendered by him/her.

RESPONSIBLE PARTY SIGNATURE X \_\_\_\_\_ DATE \_\_\_\_\_

(I agree to pay in full for services provided)