Deanna K. Weiss, Psy.D.
Licensed Clinical Psychologist
1755 Park Street, Ste. 300 Naperville, IL 60563
Office: 630-355-5280
napervillepsych.com

Patient Information

Welcome! Please complete all spaces.

First Name (client): _____ MI: _____ Last: _____

Parent's name (if client is a minor): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Cell: _____

Where may we leave a message? _____

Date of Birth (Client): _____

Age: _____ Gender: _____ Marital Status: _____

Who referred you to us? _____

Primary Insurance Company (Circle)**:** BCBS Aetna Cigna Out-of-Network:

Name on Insurance Card: _____

ID#: _____ Group #: _____

Insured's Address and Telephone (if different from client): _____

_____

Date of Birth: _____

Secondary Insurance Company: _____

Name on Insurance: _____

ID#: _____ Group #: _____

Insured's Address and Telephone (if different): _____

_____

Date of Birth: _____

I hereby authorize Deanna K, Weiss, Psy.D. to furnish my insurance company with all information that the insurance company may request concerning my present illness. I hereby assign Deanna K. Weiss, Psy.D, all monies to which I am entitled for expenses relative to the services received. I understand that I am financially responsible to said psychotherapist for charges not covered by this assignment.

_____ _____

Signature of Patient or Legal Guardian Date

Dear Patient:

If you would like to receive a reminder of your appointments, please indicate your interest by providing your email. All reminders will be discreet and only indicate the practice name, appointment date and time.

Please note that this notification is only a courtesy and does not affect our cancellation policy.

NAME: _____

EMAIL:_____

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PRACTICE ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices HIPPAA, Outpatient Services Contract and the failed appointment/late cancellation policy.

Name:_____Birthdate:_____

Signature:_____

Date:_____

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Welcome,

Please review, fill out and sign the attached information packet. I will need to make a copy of your insurance card, so please have it available. We will review any questions at the beginning of your appointment.

Thank you.

New Client Packet

1. Welcome
2. HIPPA Info
3. Patient Information*
4. Credit Card Authorization*
5. Office Policies Signed Acknowledgement*
6. Failed appointment/late cancellation policy*
7. Outpatient Services
8. Private Practices Acknowledgment/ Signed Outpatient Services Contract*
9. Appointment notification form

For office use only:
Admin/Intake Form
Client Initial Consultation Intake Form

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**Signature required*

OFFICE POLICIES

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary in our area. Since the insurance contract is an agreement between you and your insurance carrier, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Insurance Coverage:

Payment is due at the time of service. Patients who are members of PPO's may be required to pay a co-payment, which is due at the time of service. If applicable, authorizations for these services must be obtained prior to the office visit. We are participating providers in several PPO's and will file insurance claims only for patients who are participants in these programs. All other patients will receive a superbill that contains all the codes necessary for obtaining insurance reimbursement.

Failed Appointment/Late Cancellation Policy:

Appointments must be cancelled by 9:00 a.m. on the previous business day or you will be charged for a late cancellation. This means that Monday appointments need to be cancelled by Friday at 9:00 a.m. Arrivals of more than 15 minutes late will need to be rescheduled, and you will be charged at the full fee. Any charges applied must be paid prior to scheduling your next visit. These charges are not billable to your insurance company.

Note: We DO NOT call to confirm appointments.

Delinquent Accounts:

Accounts with no payment activity, or those with previous payment arrangements that are not being adhered to will be considered past due after 60 days and may be referred to an outside agency for collection. All cost associated with this action will be the responsibility of the patient. Accounts with balances past 90 days will be subject to a finance charge of 1.5% per month. Patients with delinquent bills may also be dismissed from the practice.

Confidentiality:

Mental health law indicates that we can neither confirm nor deny that a patient is being seen in our practice without **written** authorization from the patient. This includes **all** family members. Please be advised questions regarding billing matters will be discussed with **only** the patient or guardian.

_____ _____

Signature of Responsible Party Date

_____ _____

Signature of Co-Responsible Party Date