

# LindaBerlin, Psy.D.

# &

# PsychologicalAssociates, P.A.

## ORIENTATION INFORMATION

Welcome to Linda Berlin, Psy.D. & Psychological Associates, P.A. In addition to completing the forms in this packet, we are required by law to provide you with a Notice of Privacy Practices and have you sign a consent form (on the back of this packet) allowing us to use and disclose your health information. We have enclosed both a short version and a complete version of our Notice of Privacy Practices for you. You may also find a copy of our Notice of Privacy Practices posted in our waiting room, on our website at [www.Psychologicalassoc.com](http://www.Psychologicalassoc.com), or by requesting a copy from one of our office staff or your therapist.

It is essential that the patient, or the patient's legal representative:

- (1) Completely fill out ALL parts of this packet.
- (2) Completely read our Notice of Privacy Practices (enclosed within).
- (3) Sign the "Consent to Use and Disclose Your Health Information" form on the back page of this packet **prior** to your therapist meeting with you.

If you have any questions or concerns regarding any of the preceding information, please do not hesitate to ask your therapist.

NAME OF PROVIDER OF SERVICES: \_\_\_\_\_

DATE \_\_\_\_\_

PLEASE PRINT CLEARLY

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_  
 PATIENT'S SS# \_\_\_\_\_ REFERRED BY \_\_\_\_\_ PATIENT'S OCCUPATION \_\_\_\_\_  
 PATIENT'S ADDRESS: \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
 TELEPHONE: H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_  
 PERSON NOT LIVING WITH YOU TO CONTACT IN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_  
 INSURED'S NAME: \_\_\_\_\_ INSURED'S SS# \_\_\_\_\_ INSURED'S BIRTHDATE \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Only fill out this section if the patient is a minor or someone other than the patient is responsible for payment. If someone other than the patient is responsible for payment of services, a Financial Agreement MUST be signed by the Responsible Party.

RESPONSIBLE PARTY \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
 HOME ADDRESS OF RESPONSIBLE PARTY \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
 RESPONSIBLE PARTY'S TELEPHONE: H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_  
 SS#: \_\_\_\_\_ RESPONSIBLE PARTY'S EMPLOYER \_\_\_\_\_

**HOW MAY WE CONTACT YOU?**

What telephone numbers may we call to confirm appointments?

PATIENT:            H        W        C        Do Not Confirm        (Circle all that apply)  
 RESPONSIBLE PARTY:        H        W        C        Do Not Confirm        (Circle all that apply)

Should correspondence be sent to the patient's address or the responsible party's address?

(Circle One)        Patient                      Responsible Party                      Neither

If you answered "Neither," please provide us with an alternate address in which to send correspondence.

By signing below you agree that we may contact you in the manner indicated above.

Signature: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the therapist and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

This office request an assignment of benefits for our files, should your account become delinquent, requiring this office to receive the insurance reimbursement.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including private insurance, and other health plans to: LINDA BERLIN, PSY.D. & PSYCHOLOGICAL ASSOCIATES, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCIAL AGREEMENT**

This is a Financial Agreement between \_\_\_\_\_ hereinafter known as "I", "You", "Your" or "My" AND **Linda Berlin, Psy.D. & Psychological Associates, P.A.**, hereinafter known as the "Corporation", "We" or "Us". As an independent contractor of the Corporation, your therapist has entered into a separate agreement with the Corporation in which your therapist has assigned the collection of his/her fees to the Corporation.

Your financial obligation depends on whether you are using managed health care (such as an HMO or PPO) or whether you are choosing not to use insurance or you have an insurance plan which pays a percentage of the total charge (such as 80/20 split plans).

Your therapist has agreed to provide counseling and/or psychotherapy to you at the rate of \$\_\_\_\_\_ per session. (Self pay individuals and 80/20 split or similar indemnity insurance plan).

**OR**

If you are using managed care, your therapist has entered into a contract with your managed care company to provide services at a specific rate which requires you to pay a copay of \$\_\_\_\_\_ per session\*\*\*. (For individuals using Managed Care such as HMO's and PPO's).

\*\*\* The copay amount indicated above is our good faith belief based upon information obtained by us from your insurance company. However, it is possible that after submitting your insurance claim, it is determined by your insurance company that your insurance policy requires a copay of an amount different from that stated above. Please be aware that should your copay be greater than that stated above, you will be responsible for the additional funds due.

*Please initial EACH line acknowledging your agreement to and acceptance of the following additional terms of this Agreement.*

\_\_\_\_\_ I understand and agree that I am directly responsible to the Corporation for all bills submitted to me for services rendered by the patient's therapist.

\_\_\_\_\_ I understand that payment for each session is due prior to obtaining services and agree to pay the above-stated amount due prior to each session.

\_\_\_\_\_ **24 HOUR LATE CANCELLATION/NO SHOW POLICY:** I understand and agree that I will be charged for appointments which are cancelled with less than 24 hours notice and for appointments for which I do not show.

*If you are using insurance, you must initial these statements as well. If you are not using insurance, you may skip this section.*

\_\_\_\_\_ I understand and agree that although the Corporation will contact my insurance company in order to obtain benefits, the benefits information given to the Corporation may be different than what my insurance company actually pays. (ie., when we call to obtain your insurance policy benefits, we may be told that your copay is only \$15; but after submitting your claim, we learn that your copay was actually \$25, you will be responsible for the additional \$10 dollars that you are required to pay by your insurance company).

\_\_\_\_\_ Therefore, I agree that I am ultimately responsible for obtaining the copay amount per visit from my insurance company prior to services being rendered and should I or the Corporation be misinformed by my insurance company as to the amount of my copay, I will be responsible for any additional funds due to the Corporation.

\_\_\_\_\_ I understand that if my insurance company requires Pre-Authorization prior to being seen by my therapist, I will make the necessary arrangements to obtain Authorization prior to being seen by my therapist.

\_\_\_\_\_ I further agree that if I fail to obtain this Pre-Authorization or change insurance companies after obtaining Pre-Authorization without informing the Corporation prior to services being rendered, I will be responsible for the **full** contracted rate agreed on between my therapist and my prior insurance company which authorized the services rendered.

\_\_\_\_\_ I agree to pay any deductible amount, co-insurance, or any other balance not paid by my insurance company.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of Collection. By signing below, you acknowledge your understanding and acceptance of the terms of this agreement.

\_\_\_\_\_  
Name of Responsible Party

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number of Responsible Party

\_\_\_\_\_  
Patient Name

## Consent to Use and Disclose Your Health Information

This form is an agreement between you, \_\_\_\_\_ and Linda Berlin, Psy.D. & Psychological Associates, P.A. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here:

\_\_\_\_\_

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

**IF YOU DO NOT SIGN THIS CONSENT FORM AGREEING TO WHAT IS IN OUR NOTICE OF PRIVACY PRACTICES (NPP), WE CANNOT TREAT YOU.**

In the future, the law may require that we change how we use and share your information. Therefore, our Notice of Privacy Practices may also change. If we do change it, you can get a copy from our Web Site, [www.psychologicalassoc.com](http://www.psychologicalassoc.com) or by calling our privacy officer at (954) 227-2700.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

\_\_\_\_\_  
Signature of client or his other personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to the client

\_\_\_\_\_  
Description of personal representative's authority

Date of NPP: April 14, 2003

Copy of NPP given to the client/parent/personal representative.