Adult New Patient Billing Forms

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PATIENT INFORMATION

Please fill out all applicable spaces and print legibly * **Denotes a Required Field**

* Patient's Last Name	* First	Middle	☐ Mr ☐ Mrs	☐ Miss ☐ Ms	Marital Status ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

* Social Security	Home Tel	Mobile Tel	Work Tel	* Birth Date	* Age	* Sex
				/ /		☐ M ☐ F

May we call this number?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
May we leave a message?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

* Street Address	* City	* State	* Zip Code	E-Mail Address

* Do we have permission to contact you at the above address concerning billing and medical matters? ☐ Yes ☐ No

	* Name a Local Friend or Relative	May we call her/him? ☐ Yes ☐ No	* Relationship to Patient

Street Address	City	State	Zip Code	* Telephone

Referred By: Name: Tel: Online: Publication:

FINANCIAL RESPONSIBILITY

* Last Name	* First	Middle	Social Security #	Relationship to Patient May we contact him/her?

* Address	* City	*State	*Zip Code	Indicate your Preferred Method of Payment	We accept ☐ Cash ☐ Credit Cards ☐ Check

Visa/MC/Amex/Diners/Discover Card #	* Expiration Date	*Security Code[1]	* Signature

CONSENT I consent to the rendering of medical care, which may include psychotherapy and medication treatment and any such treatment as Aaron Alaniz, MD deems necessary. I understand that I am not compelled to engage in psychotherapy and/or take medication and I may decide to stop it at any time. I understand that it is my responsibility to promptly notify Aaron Alaniz, MD if there are any unexpected changes in my condition and/or if any problems arise relating to my treatment and/ or if I do decide to terminate treatment. I also understand that although Aaron Alaniz, MD believes that psychotherapy and/or medication will help me, there is no guarantee that my condition will improve or as to the results that might be expected. I understand that I have the right to consent or to refuse consent, to any proposed procedure or therapeutic course.

FINANCIAL RESPONSIBILITY AND FINANCIAL AGREEMENTS I acknowledge full financial responsibility for services rendered by Aaron Alaniz, MD. I further guarantee the full and complete payment of all charges for medical care rendered by Aaron Alaniz, M D. This is a guarantee of payment and not merely of collection, and I agree to be directly responsible for the payment of all charges. I understand that the payment of charges incurred is due at the time of service or must be received within 30 days of the date of the statement unless other definite financial arrangements have been made prior to treatment. I understand that Aaron Alaniz, MD reserves the right to charge a reasonable, cost-based fee for costs related to copying, labor and supplies, telephone transmissions and postage incurred at my request. I understand that I may be asked to sign a Payment Schedule Agreement for any overdue balances.

CREDIT/DEBIT CARD AUTHORIZATION AGREEMENT I, as a Cardholder/s, authorize transfer of all fees, unpaid amounts and/or balance/s to my card above prior to services or as such payments become due and without further notice to or authorization by me. By giving signature above I authorize my credit card company to accept the charges in lieu of an imprinted sales draft.

NON-PARTICIPATING PROVIDER I understand that Aaron Alaniz, MD is a non-participating provider; that is a physician non-affiliated with an insurance company.

OUT-OF-NETWORK BENEFITS AND NON-COVERED SERVICES I understand that it is my responsibility to contact the insurance company to determine my out-of-network benefits. I understand that some benefits are not covered under my plan, and coverage determinations and payments of claims are subject to all the eligibility, coverage, exclusions, and limitations listed in my contract. I further understand that I may be charged for services which may be deemed as medically unnecessary by my insurance carrier. I assume full financial responsibility if benefits for non-covered services are denied.

PRE-CERTIFICATION OF SERVICES I understand that is my responsibility to obtain pre-certification of services prior to the initial consultation or service. I further understand that it is my responsibility to maintain and renew such pre-certification of medical services during the course of treatment. I assume full financial responsibility if benefits for non-authorized services are denied.

CANCELLATIONS FEE Please be advised that we reserve the right to charge for missed appointments not cancelled with at least 24 hours notice.

MISSED APPOINTMENTS FEE A charge equal to the fee for the session will be assessed to your account for failure to attend a scheduled session.

DISCLOSURES I hereby certify that to the best of my knowledge and belief, all statements made on this form are complete, true and correctly recorded. I also understand that failure to complete a required section or to enter accurate, complete and updated personal and medical information may result in denial of all benefits or may delay the processing of my information and/or claim.

By signing this form, I am aknowledging that I have read, understand and agree to all of the above and give my consent for treatment

** Signature of Patient/ Parent or Legal Guardian*

_____

* Date

_____

Amex 4-digit number on front of your credit card **MC/Visa/Disc.** 3- or 4-digit number printed in the signature field on back of your credit card

INFORMED CONSENT

Listed below are important facts regarding your treatment. Please read this page carefully. If you have any questions, please ask Dr. Alaniz or staff.

Services: *Initial evaluation typically last 60 minutes for adults to determine a medical diagnosis and treatment plan. Follow-up visits range from 20-30 minutes per session. You and Dr. Alaniz will discuss your treatment needs and schedule follow-up visits accordingly. If you have questions about your care,* ***please ask for clarification.***

Previous Records: *In order to facilitate our work, records from your previous mental health treatment(s) may be requested with your permission.*

FEE SCHEDULE

ADULT DIAGNOSTICE INTRVIEW	$200.00
ADULT FOLLOW-UP	$150.00
$150.00	No Shows for appointments without 24 hour notice
$150.00	Reschedule/Cancellation without 24 hours notice
$0.00	Phone Consultation 1-5 Minutes
$50.00	Phone Consultation 6-15 Minutes
$100.00	Phone Consultation 16-30 Minutes (Moderate)
$150.00	Phone Consultation 31-59 Minutes (Extended)
$35.00 per 15 minutes	Written Notes to be completed by the physician for non-legal purposes.
$35.00	2nd Stimulant Prescription which requires an Additional Prescription by the Physician
$200.00 per hour	Review of records for court and other legal purposes and requires a $1000.00 retainer to be paid prior to these services.
$350.00 per hour	*Court Testimony-to include travel time if within 50 miles, stand-by efforts, written and oral correspondence with legal representative, and any other work related to the case. Requires $3500.00 retainer to be paid prior to these service. For testimony that occurs in the court room on the stand, this will be billed in 4 hour increments.*

Travel time beyond 50 miles will require this hourly fee billed at 8 hours per day regardless of the amount of time spent on the case ~ In addition to all expenses for purposes of travel, lodging and meals, a $7000.00 retainer fee is due prior to travel.

Missed Appointments: *If you need to cancel an appointment, please give 24 hours notice. If 24-hour notice is not given, you will be charged the full appointment fee. Insurance companies will not reimburse for this charge.*

Termination of Doctor-Patient relationship: failure to follow the prescribed treatment plan, failure to keep routine appointments, and/or failure to meet financial obligations may result in termination of services. Medical records will be provided to your physician upon receipt of signed medical release form.

Patient's/Guardian's Signature: _____ *Date:* _____

FINANCIAL RESPONSIBILITY AND PATIENT INFORMATION

As a courtesy to you, I will give you an itemized statement for you to send to your insurance company for the day of your appointment.

If you are uncertain about what your insurance company covers for psychiatric benefits, I recommend **you call them to verify and explain your benefits.** Services I provide may be considered "non-covered services" by your insurance plan. Regardless of your insurance company's arbitrary determination, you are responsible for payment of services at the time of your appointment.

Minors: Please do not leave your child unattended in the reception area, as we cannot be responsible for their well being.

Missed Appointments: If you need to cancel an appointment, please give 24 hours notice, if you do not cancel your appointment 24 hours in advance, you will be charged your regular fee.

Returned Check Fee: Please contact my office immediately upon notification of a NSF check. A $25.00 fee will be charged by my office for a bad check. Your check will be re-deposited after two days unless you notify my office otherwise.

Financial Arrangements: If you are experiencing difficulty meeting your financial obligations for any reason, please speak with me about your concerns. I will try to work out an arrangement that will make it possible for you to meet your financial obligations. However, if you refuse to pay for services rendered or to make a financial arrangement, I send open accounts to collections (and is also considered a breach of the doctor-patient relationship, which may result in termination of services).

My signature below indicates that I have read and agree with the above financial policy and payment agreement.

_____ _____

Patient Signature (or responsible party) Date Signed

CONSENT FOR MEDICAL TREATMENT

Please read the following carefully before signing.

I do hereby voluntarily consent to such treatment involving routine diagnostic procedures and medical treatments as considered necessary by Aaron Alaniz, M.D. and his assistants, or his designees. I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered.

I further authorize and instruct Aaron Alaniz, M.D. to release to the persons or organizations herein specified, or to any other agency concerned with the payment of my charges or further treatment, any and all medical information, including copies or records requested or required by such person or organizations.

I understand that any of the above requested information may include results of Human Immunodeficiency Virus (HIV) test if any were performed.

Furthermore, I understand that any of the above requested information may include results of alcohol/drug (substance) abuse screening and/or diagnosis and treatment of psychological disorders.

_____ _____

Patient's/ Guardian's Signature *Date*

Private Pay Acknowledgement

Non-Participating Provider

Aaron Alaniz, MD is a non-participating healthcare provider; that is a physician with no contractual relationship with any insurance company. You will be responsible for all balances not covered or paid by insurance in accordance with any arrangements that you have made with them.

Coverage determinations and payments of claims are subject to all the eligibility, coverage, exclusions, and limitations listed in your contract.

- We strongly encourage verifying your out-of-network benefits prior to your initial consultation.

Precertification of Services

Your insurance company may require pre-certification for medical services provided by a non-participating provider. Since Dr. Alaniz has a non-participating status with your insurance company, it is your obligation to obtain and renew the authorization of services.

Pre-certification is when you notify in advance your insurance company of medical services provided by non-participating providers and it is generally required by most policies. Although requirements can vary from policy to policy, the purpose of pre-certification is to determine if a service is medically necessary. Your insurance card may indicate the pre-certification telephone number; otherwise you should call the toll- free number for Customer Service. Please refer to your plan documents for your pre-certification requirements.

- Please follow the pre-certification procedure in order to maximize your benefits. Failure to do so may result in denial of benefits.

I acknowledge that I am requesting services from Aaron Alaniz, M.D. on a private pay basis. I understand that if I do choose to use my insurance coverage in the future that services previously rendered will not be eligible for coverage or back billing.

Date: _____

Patient's/Guardian's Printed Name: _____

Patient's/Guardian's Signature: _____