Sarah H. Kramer, Ph.D., LLC

6401 Eldorado Pkwy, Ste 231
McKinney, TX 75070-6199
469/625-1162 Fax: 469/625-1029
drsarah@drsarahkramer.com
www.drsarahkramer.com

CLIENT REGISTRATION

Name: _____ Gender: F M O DOB: _____

Address: _____
Street address City State ZIP

Telephone 1 (belongs to) _____ Telephone 2 (belongs to) _____

Employer (or school): _____ Position (or grade): _____

Email (parent's for teen): _____ Physician: _____

Emergency contact: (Name)_____ (Phone)_____ (Rel.)_____

GUARANTOR (PERSON HOLDING INSURANCE)

Name: _____ Gender: F M O DOB: _____

Address (if different): _____

Employer: _____ Guarantor phone: _____

Insurance name, ID and group number (please have card available for copying):

_____

Secondary Insurance (if any): _____

PAYMENT INFORMATION

Please initial in the blanks below to indicate your understanding and agreement:

____ I understand that obtaining pre-certification from my insurance company is my responsibility, though Dr. Kramer's office will provide help whenever possible. I agree to pay all costs that are incurred but not covered by insurance, for whatever reason. Co-pays, deductibles, charges for completing forms, and missed visit or late cancellation fees are my responsibility and are due at the time of the scheduled visit or when services are rendered. **I further understand that, regardless of my expected out-of-pocket costs, I am required to keep a credit or debit card on file, which will be used to pay for any missed visits or late cancellations (less than 24 hours notice).** *This requirement may be waived by Dr. Kramer at her discretion*. The same card also may be used to pay for my session cost, or I may substitute a different payment method at any appointment.

____ For insurance filing purposes, I hereby assign all medical benefits, including major medical benefits to which I am entitled under private insurance and other health plans, to: Sarah H. Kramer, Ph.D., LLC. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges, *whether or not* paid for by said insurance. I hereby authorize assignee to release all information necessary to secure payment.

My signature below signifies that I have read, understand, and agree to all the terms above:

Signature *(required)* Date Print Name

6401 Eldorado Pkwy, Ste 231
McKinney, TX 75070-6199
469/625-1162 Fax: 469/625-1029
drsarah@drsarahkramer.com
www.drsarahkramer.com

Sarah H. Kramer, Ph.D., LLC

Client Name: _____

CONSENT TO TREATMENT

- **NATURE OF SERVICE**

  I acknowledge that I have received the Informed Consent, HIPAA documents and Information for Parents (if applicable), read them and had any questions fully answered. I hereby consent to engage in treatment provided by Sarah H. Kramer, Ph.D. If I bring my child under age 18 for treatment, I know that I must provide legal documentation that I have the right to seek such care on their behalf. I understand that I (and my minor child, if applicable) will participate in setting treatment goals and periodically evaluating progress towards them, and that successful therapy requires my/our active participation. I also understand that I may stop treatment at any time, and the only obligation I will have is the payment for any sessions, written materials or missed visits incurred up to that time. The only risk is the loss of potential benefit from therapy. I understand that no guarantees are being made as to outcome or results of treatment, though Dr. Kramer will use her best professional skills on my behalf.

- **MEETINGS, INSURANCE AND CANCELLATION POLICY**

  Therapy sessions occur by appointment on the hour and *last 45-53 minutes*. The fee for the initial visit is $175 and for second and following visits, $120-150. Different fee schedules may apply if insurance is used. I know that full payment of the copay, deductible or session cost is due at the time of visit. I am aware that Dr. Kramer is an in-network provider for Blue Cross Blue Shield, Tricare, Medicare, Cigna and Aetna and will pre-certify and file these insurance claims on my behalf. I am responsible for any deductible, copays or co-insurance costs and these are due at the time of my visit. I also understand that Dr. Kramer is an out-of-network provider for other insurance plans and that she is happy to provide documentation for visits so that I can file for reimbursement myself.

  I know that I am responsible for scheduling appointments**. If I cancel or reschedule with less than 24 hours' notice, my credit card on file will be charged $65.00. If I no-show for a visit, I will be charged $130.00.** I understand that my insurance company will not be responsible for these charges and they will not be billed to insurance.

- **APPOINTMENT REMINDERS/COMMUNICATION**

  I have read the separate document explaining Dr. Kramer's social media policy and agree to those terms. I am aware that I can call the office and leave a confidential voicemail, use encrypted email via TherapyAppointment.com, or I can send non-emergency texts or leave voice messages at 469-708-2997 **if** I have signed the related consent form. I know Dr. Kramer does not offer emergency services; if I have an emergency, I should go to an Emergency Room or call my physician or psychiatrist. I agree that *even if I do not receive a courtesy reminder, it is my responsibility to attend my appointment* to avoid missed visit charges.

Signature: _____ Printed Name: _____ Date: _____

Sarah H. Kramer, Ph.D., LLC

6401 Eldorado Pkwy, Ste 231
McKinney, TX 75070-6199
469/625-1162 Fax: 469/625-1029
drsarah@drsarahkramer.com
www.drsarahkramer.com

CREDIT CARD AUTHORIZATION

I hereby grant Sarah Kramer, Ph.D., LLC authorization to process credit/debit charges.

Client name: _____ DOB: _____

Initial below:

☐ With or without my credit card present, I authorize Sarah H. Kramer, Ph.D. LLC to use the card number provided below to process charges or fees assigned to the client listed above.

☐ I authorize Sarah H. Kramer, Ph.D. to be compensated for any no-shows (not appearing for scheduled visits and not cancelling beforehand) or late cancellations (cancelling or rescheduling less than 24 hours before time of appointment). These charges are not covered by insurance and will not be filed by our office. For missed appointments, a fee of $130 will be charged. For late cancellations, the charge is $65. **After two consecutive missed appointments (no-shows), the client will be considered to have discontinued treatment with Dr. Kramer.**

Please complete all information below:

Type of card (circle) MasterCard VISA Discover AmEx

Cardholder's name _____ (as shown on card)

Card number _____

Expiration date (month/year) _____

Security code (3 or 4 digits) _____

Billing address _____

City _____ State _____ ZIP _____

Authorized signature: _____

OPTIONAL FORM

REQUEST FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ AUTHORIZE: Sarah H. Kramer, Ph.D.
(Name of client)

6401 Eldorado Pkwy, Suite 231

McKinney, TX 75070
Business cell: 469-708-2997

TO EXCHANGE WITH ME BY NON-SECURE MEDIA (such as SMS or other standard text programs) THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information related to the scheduling of, or lateness for, meetings or other appointments
- A link to Dr. Kramer's website for access to directions, new patient paperwork etc.
- A statement announcing my arrival at Dr. Kramer's office (using my first name and last initial only, please)

TERMINATION

O This authorization will terminate _____ days after the date of signing.
OR
O This authorization will terminate when the following event occurs: discharge or no visits for 3 months or longer

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am ***not*** required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

I also understand that Dr. Sarah Kramer makes available to me the following means of communication that are designed to be secure and to maintain confidentiality, and I still choose to authorize the above-named non-secure means:

--Encrypted email via TherapyAppointment.com
--Secure voicemail at 469-625-1162

.

_____ _____
Signature of client (or parent, if client under age 18) Date

_____
Print Name of Client