861-D North Dean Road ⦁Auburn, Alabama 36830

(334) 887-4343 Phone ⦁ (334) 887-5656 Fax

[www.auburnpsychology.com](http://www.auburnpsychology.com)

APG

Auburn Psychology Group, LLC

**CLIENT INFORMATION FORM**

Client's Legal Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

**Permanent Home Address (If different than above)**

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Would you like reminder texts for future appointments?**

Yes \_\_\_\_ No \_\_\_\_\_

**Express Prior Consent to Contact Consumer by Cell Phone:**

By signing here, I give permission for Auburn Psychology Group, LLC and our agents to contact me by telephone using the numbers provided above. Depending on my cell phone contract, I may be charged fees for this service by my cell phone provider. I may also receive e-mails or texts, using the e-mail addresses or cell phone numbers I provided. I may also be contacted using prerecorded voice messages.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

Who is responsible for payment?

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By providing this information, I consent to Auburn Psychology Group, LLC to contact the responsible party about my financial obligations to the practice. However, I understand that I am still responsible for any unpaid portions of the bill.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

Name of **Primary Insurance** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder's Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder's Relation to the Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder's Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_

Policy Contract Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder's Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of **Secondary Insurance** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder's Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder's Relation to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder's Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder's Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*Only complete the next few boxes if the client is a minor. Otherwise, continue to Fee Agreement\*\*\***

Who holds legal custody of the minor? \_\_\_\_\_\_\_\_\_\_What is the custodian's relationship to the child? \_\_\_\_\_\_\_\_\_

Name of Parents or Primary Custodian Guardians \_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parents If Different Than Above

Parent 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status of Parents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stepparent's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stepparent's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At my request, Auburn Psychology Group, LLC will bill my insurance carrier directly. The practice cannot guarantee if or how much my insurance will pay. It is my responsibility to know my outpatient mental health benefits. My share of the fee is due at the time of service. Full payment for the initial session is due at the time of service. Whoever is specified as responsible for the bill must pay for all fees in the event of nonpayment or reduced payment by my insurance company. Should my account become delinquent, my name and other information relevant to collections may be turned over to a collection agency.

There will be a late fee of $20 per month for non-payment on my portion of the account. This means that I must pay any portion of my balance that my insurance carrier does not pay in full, as well as any late cancellation/no-show fees.

If I have not been seen in this office for an appointment in the past consecutive six months, my file will be closed, and I will be considered a new client if I return for future therapeutic services.

Billing will occur at the end of each month for psychological services at the rate of $160.00 per hour for initial intake appointment; $140.00 per 45-50 minute session; $160.00 per hour for assessment (including consultation, test administration, scoring and interpretation, report preparation, and consultation); $160 per hour for phone calls (broken down into 15 minute increments); $10.00-$30.00 for records to be mailed/released; and $200.00 per hour for legal consultation, testimony, preparation, and telephone consultation.

For psychological assessment services, including evaluations for learning disorders and ADHD, the costs typically run between $800 and $2,500. For those evaluations, $160 will be due at intake, $500 will be required at the second visit, and another $160 will be due at the feedback session. The full balance will be due within three months of the feedback session. We will refund any overpayment after settlement from the insurance company. We will happy to place a credit card on file to assist with this process.

I understand that missed appointments that are not cancelled 24 hours in advance will be charged. These missed appointments cannot be filed with my insurance carrier and I will be held financially responsible for the entire amount as noted above. Auburn Psychology Group, LLC will abide by a strict 24-hour policy.

By signing, I agree to these four statements above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

**AGREEMENT TO PAY**:

I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.3%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemptions under the laws of the constitution of the State of Alabama and any other state. I also agree, in order to service my account or to collect monies I may owe to Auburn Psychology Group, LLC, that its agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me.

I have read this disclosure and agree that Auburn Psychology Group, LLC, its employees and/or agents may contact me as described above.

As a courtesy, Auburn Psychology Group, LLC will file insurance after all necessary information is supplied to this office. However, the practice cannot guarantee payment by the insurance company. We are not currently in network with any insurance companies. It is my responsibility to keep abreast of, and notify this office of, any changes regarding insurance coverage, i.e., deductibles, percentage paid, yearly maximums, etc. Even if I do not want to file insurance, I am fully aware that I am responsible for all charges incurred.

By signing here, I agree to the above agreement to payment statements.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

I have received and reviewed a copy of HIPAA Privacy Policy and the Auburn Psychology Group, LLC Psychologist/Client Services Agreement, and agree to the information therein.

Signature of client (aged 14 or older) or legal representative.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature