APG Auburn Psychology Group, LLC

**Client Information Form**

**Client:** Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date/Age:\_\_\_\_\_\_\_\_\_/\_\_\_\_\_

Married\_\_\_\_\_\_\_\_ Single \_\_\_\_\_\_\_\_\_ Divorced\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_\_\_\_\_ Driver’s License #/ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_

Permanent Home Address (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_

**Phone Numbers: OK to leave a message?**

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

Would you like a reminder **text** for future appointments? Yes\_\_\_\_\_ No\_\_\_\_\_\_

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

By initialing 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.

Initials: \_\_\_\_\_\_\_\_

**Who is responsible for payment?**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Phone #: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

By providing this information, I consent to all 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 my bill.

Initials: \_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

**Primary Insurance Information Secondary Insurance Information**

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

Name of Primary Insurance Name of Secondary Insurance

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

Policyholder’s Full Name Policyholder’s Full Name

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

Policyholder’s Relation to Patient Policyholder’s Relation to Patient

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

Policyholder’s Date of Birth Policyholder’s Date of Birth

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

Policyholder’s SSN Policyholder’s SSN

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

Policyholder’s Employer Policyholder’s Employer

**\*Only complete the rest of this page if client is a minor child. Otherwise, continue to the next page\***

Who holds legal custody of the minor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the custodian’s relationship to the child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information for Parents or Primary Custodial Guardians:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Work Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Names of Parents if Different from Above:**

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

Marital Status of Parents: Married \_\_\_\_\_\_\_\_ Divorced \_\_\_\_\_\_\_\_ Separated\_\_\_\_\_\_\_\_\_\_

Stepparent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stepparent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEE AGREEMENT**:

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.

Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

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.

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

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.

Initials: \_\_\_\_\_\_\_\_\_\_

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. 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.

Initials: \_\_\_\_\_\_\_\_\_

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 Date