**PATIENT INFORMATION SHEET**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell ph#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home ph#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list any special privacy instructions (places, times, people not to call. OK to leave messages?)

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

How did you hear about the practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible party for payment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Release/Request Information To/From Primary Care Physician**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, date of birth: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_, hereby authorize Bona Vita Wellness and Psychiatric Center to obtain information from and share information with my primary care physician indicated below:

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature of patient/parent/legal guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby acknowledge that I received a copy of the Notice of Privacy Practices of Bona Vita Wellness and Psychiatric Center on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT FOR ASSESSMENT AND/OR TREATMENT:**

**Payment policy:** We do take some insurance, however you should inquire about our insurance coverage policies as these could change at any time in the future. If we are preferred or authorized provider for your insurance carrier you will be responsible for the co-payment at the time of the appointment. For out of network or cash based, the full fee is due at the time of your visit. I will give you a receipt to submit to your insurance. Your reimbursement will depend on what you have for out-of-network benefits and your insurance will mail it to you directly.

**Cancellation policy:** We do not double-book appointments; therefore, a missed appointment cannot be filled without adequate notice. 48-hour notice is required for cancellations to avoid being charged. The same day cancellations will be charged $75. No show appointments will be charged $150.

**Fees:**

Cash Base/Out of Network:

Initial Consultation (up to 1 hour): $250 per session via check, credit card, or cash

Therapy session (45 minutes): $200 per session via check, credit card, or cash

**Billing fee:**

Your balance must be paid at each appointment in order to minimize expensive book keeping. If your payment is not collected at the time of the visit, there will be a $15 billing fee assessed. There will be an additional $15 fee each time a bill is sent. There will be a $35 fee for all returned checks.

**Crisis procedure:** In the event of a crisis or emergency, I ask you to please call 911 or go the nearest emergency room/hospital and get immediate help. If I am currently working with you, in the event of an urgent matter, you may call my voicemail and leave a message to explain the situation; still the clinic line is NOT TO be used for solving emergency crisis. All other phone calls will be answered promptly, in most cases by the following business day.

**Phone policy:**

I am happy to discuss logistics or do short check-ins from time to time during business hours if you have questions or concerns. Calls that last over 10 minutes will be considered phone sessions and will be charged at my usual rate, pro-rated according to how much time was spent. Billing of phone sessions is different from in-person sessions, so your insurance may not be able to offer you similar reimbursement. This policy also applies to time spent on the phone with your insurer, and unfortunately insurers will not reimburse for this.

By signing below, you are indicating that you are in agreement with policies listed above, including fees and charges.

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

Signature

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

Print Name

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

Date