GUTTMAN & PEARL ASSOCIATES Therapist: ______________________________

Patient (1) Name:______________________________________ Preferred Gender: ________

Mailing Address:___________________________________ Home Phone: _______________________

City, State, Zip:___________________________________ Office Phone: _______________________

D.O.B.: ___________Employer: _____________________ Cell Phone: _________________________

E-mail Address:___________________________________ **Social Security Number:**_____________

Marital Status: ______________ How long in Relationship: ____________ Child(ren) age(s): ____________

Patient (2) Name: ____________________________________ Preferred Gender: _________

Mailing Address:___________________________________ Home Phone: _______________________

City, State, Zip:___________________________________ Office Phone: _______________________

D.O.B.: ___________Employer: _____________________ Cell Phone: _________________________

E-mail Address:____________________________________ **Social Security Number:** _______________

Emergency Contact, Relationship, & Phone #:____

Referred by: _________________________________ ***Internet site:*** _________________________________

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We welcome you as a patient and appreciate the opportunity to provide you with professional care. We hope that the following information will answer your questions regarding billing procedures.

Your appointment time is reserved specifically for you. If you are unable to keep your scheduled appointment, or need to re-schedule for any reason, please give us **24 hours notice.** **Cancellations can be made either by phone or email.** With this notice, we have the opportunity to fill your open session. **Without this notice, you will be billed for the session**. In case of snow, there will be no charge for cancelled appointments as long as you phone in your cancellation in advance.
_____ **Client initial of understanding**

Payment **in full is expected at each session.** Invoices will be provided to you, at the end of each month, which are suitable to submit to your insurance carrier/employee benefits plan for reimbursement of fees paid. Guttman and Pearl Associates is an out-of-network provider, including Medicare. Patients are responsible for payment in full and must check with their insurance plans as to whether psychotherapy services are reimbursable. Insurance companies will not typically reimburse for late cancellations or no show appointments. _____ **Client initial of understanding**

If payments are not made in accordance with Guttman & Pearl's policy notice, your account may be sent to our collection agency. If this is necessary, you will be responsible for all collection costs incurred. _____ **Client initial of understanding**

Please take the time to read the **Notice of Privacy Practices** and complete and return the **Acknowledgement of Receipt of Notice of Privacy Practices, Policies and Procedures,** which are provided by your therapist.

I HAVE HAD PROVIDED TO ME THE NOTICES AS REQUIRED BY HIPAA .I HAVE READ THE ABOVE AND AGREE TO THE STATED BILLING PROCEDURES.

Signed ______________________________________ *Date* __________________________________

Signed ______________________________________ *Date* __________________________________

Signature is mandatory prior to sessions being initiated.

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Office Use only:

DX 1 _______ **DX 2** _______ **CPT Code** _______ **1 or 2 Bills** ______ **Initial Session Date**: _______

01/18