GUTTMAN & PEARL ASSOCIATES GPA Therapist: ______________________________

Therapist Name:______________________________________ ☐ M ☐ F

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 therapist and appreciate the opportunity to provide you guidance. 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.
_____ **Therapist initial of understanding**

For group participation, you are required to pay the fee for the first six(6) sessions, regardless of your notice of cancellation. After the first six(6) sessions, 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.
_____ **Therapist initial of understanding**

Payment **in full is expected at each session.** Statements will be provided to you monthly. Therapists are responsible for payment in full.
_____ **Therapist 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.
_____ **Therapist initial of understanding**

I HAVE READ THE ABOVE AND AGREE TO THE STATED BILLING PROCEDURES.

Signed ____ ***Date*** ___________________________________

Signature is mandatory prior to sessions being initiated.

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Office Use only:

Initial Session Date:_________