Filaski Psychological Care, P.C.

Dr. Kristen Filaski, Psy. D.
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PATIENT INFORMATION

Name:_____ DOB:_____

Street Address:_____

Town:_____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Cell Phone: _____

Email:_____

Referral Source:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relation:_____

Home Phone:_____ Cell Phone: _____

INSURANCE INFORMATION

Insurance Company Name: _____

Identification Number:_____

Insurance Company Phone Number:_____

Policy Holder's Name:_____ DOB:_____

Social Security Number: _____ Sex:_____

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

*Please Read and Initial below:

_____ I request that my therapist provide professional services to me and my partner.

_____ I agree to pay a fee of:

- **$180.00** for the initial intake/consultation
- **$180.00** per session for ongoing marital therapy services
- **Unless using health insurance that the provider is enrolled with OR otherwise agreed upon in writing.**

_____ I agree that I am responsible for the charges for services provided by this therapist to me.

_____ I understand that **NO SHOW** or **Appointments Canceled Without 24 Hour Written Notice** via text or email will be charged directly to the client's credit card on file at a rate of **$50.00**

_____ I understand that Copays and Deductibles must be paid at the time of service or they will be charged directly to the client's credit card on file.

CREDIT CARD INFORMATION

_____ I understand that a credit card must be kept on file in the event that a late cancellation or no show fee is incurred. Cards are not stored electronically unless using STRIPE, they are kept in a secure locked location. If you are not willing to leave a card on file, future appointments will not be scheduled. Return checks are subject to a $40.00 return fee.

Cardholder's Name:_____

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ CVV_____ ZIP Code:_____

METHODS OF PAYMENT

You may pay by:

- Cash
- Credit Card (Mastercard, Visa, AMEX, Discover, HSA cards accepted)
- Check (Make checks payable to: **FILASKI PSYCHOLOGICAL CARE, P.C.**)

ASSIGNMENT OF BENEFITS & PAYMENT DETAILS

Please note that if your account is unpaid and we have not arranged a payment plan, legal means to obtain payment will be used. The only information that will be given to the court or collection agency will be your name, address, dates of services, and the amount due to the the therapist. You will be charged an additional 50% of your unpaid balance if sent to collections. All account balances that are unpaid will be assessed a $25.00 late charge every 30 days. All accounts will be sent to collections after 90 days past due.

I am aware that I am responsible for any amount not covered by my insurance company carrier including the deductible, and that my copayment is due at the time of services rendered. I agree to assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, other government sponsored programs, private insurance, and any other health plans to: Filaski Psychological Care, P.C.

I understand that I am financially responsible for any charges whether or not they are paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits. My signature below means that I understand and agree with all of the points above.

_____ _____

Signature of Client (or person acting for client) Date

CONSENT TO TREATMENT

I acknowledge that I have received, have read (or have had read to me), and understand the process and information about the therapy I am considering. I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may have to deal with other problems if I stop treatment. (For example, if my treatment is court-ordered, I will have to deal with the court.)

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of Client (or person acting for client) Date

OUR AGREEMENT FOR THERAPY

I agree to meet with the therapist named below at the appointment times and places we agreed upon. I have read all the materials on therapy, which have been provided to me by the therapist on their website. I believe I understand the basic ideas, goals, and methods or this therapy. I have no important questions or concerns that therapist has not discussed.

With enough knowledge, and without being forced, I enter into treatment with this therapist. I will keep my therapist fully up to date about any changes in my feelings, thought, and behaviors. I expect us to work together on any difficulties that occur, and to work them out in my long-term interest. During this process we will evaluate progress and may change parts of this agreement as needed. Our goals may have changed in nature, order of importance, or definition. If I am not satisfied by our progress toward goals, I will attempt to make change in this agreement. I may also stop treatment after giving this therapist appropriate (i.e., generally one week) notice of my intentions. I also understand that any information in this recording that could identify me in any way will not be published or given without my written consent.

My signature below means that I understand and agree with all of the points above.

_____ _____

Signature of Client (or person acting for client) Date

I, the therapist, have discussed the issues above with the client. My observations of this client's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Client (or person acting for client) Date

***This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law*