

Prime Behavioral Health, LLC
ADULT INTAKE PACKET

Client Name _____

Street Address _____ PO Box _____

City/State/Zip _____

Home Phone # _____ May we call this #? Yes No, May we leave a msg? Yes No

Daytime Phone # _____ Can we contact you here? Yes No Leave msg? Yes No

Cell Phone # _____ May we call this #? Yes No, May we leave a msg? Yes No

Client Date of Birth _____ Age: _____ Social Security # _____

Primary Care Physician & Phone #: _____

If we may email you, please provide your address below. *Bear in mind that email IS NOT SECURE. NO PRIVATE INFORMATION OTHER THAN YOUR NAME, EMAIL ADDRESS AND/OR APPOINTMENTS WILL BE INCLUDED.*

_____ @ _____

Emergency Contact Name (required): _____ Phone #: _____

Address (required): _____

Insurance Information (Copy of Insurance Card and ID is Required)

• This section is required to be filled out in full •

1) **Primary** Insurance Company _____ Ins Co Phone # _____

Employer of Subscriber _____

Name of Subscriber _____ Date of Birth _____

Address of Subscriber (if different from Client) _____

Subscribers Social Security # _____ Relationship to Client _____

2) **Secondary** Insurance Company _____ Ins. Co Phone # _____

Employer Name _____

Name of Subscriber _____ Date of Birth _____

Address of Subscriber (if different from Client) _____

Subscribers Social Security # _____ Relationship to Client _____

WE DO NOT FILE CLAIMS TO ANY THIRD INS.

CLIENT AGREEMENT

The above information is current and correct to the best of my knowledge.

I understand my insurance coverage as noted above and that I am responsible for paying the co-pay, if required, and/or the amount not covered by my insurance policy. This agreement also grants authorization to PBH to release such information as may be necessary for completion of my insurance claim with payment of benefits to PBH for services rendered.

Client Name (please print)

Client Signature

Date

Witness

Date

Revised 01/2020

Prime Behavioral Health, LLC

647 Hill Rd. North, Unit B
 Pickerington, OH 43147
 614-833-6900

711 North Columbus St., Ste. 100
 Lancaster, OH 43130
 740-653-6500

Client Intake Form

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Identifying Information			
Name: _____	Date of Birth: _____	Age: _____	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: _____	Height: _____	Weight: _____
Hair Color: _____	Eye Color: _____		

Behavioral Health				
Why are you seeking counseling?				
What issues or circumstances do you believe contribute to your problem(s)?				
How long has this problem(s) persisted? _____				
Under what conditions do the problems usually get worse?				
Under what conditions do the problems usually improve?				
<p>Have you previously been involved in counseling? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe the reasons for counseling, who provided the counseling, and the outcome.</p> <p>Counselor _____</p> <p>Reason:</p> <p>Outcome:</p>				
List your greatest strengths:				
List your greatest weaknesses:				
Psychiatric Hospitalizations: <input type="checkbox"/> None <input type="checkbox"/> Past <input type="checkbox"/> Recent				
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-right: 1px solid black; padding: 5px;"> Dates of Service: _____ # of Days _____ </td> <td style="padding: 5px;">Where & Reason (suicidal, depressed etc.)</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 5px;"> Dates of Service: _____ # of Days _____ </td> <td style="padding: 5px;">Where & Reason (suicidal, depressed etc.)</td> </tr> </table>	Dates of Service: _____ # of Days _____	Where & Reason (suicidal, depressed etc.)	Dates of Service: _____ # of Days _____	Where & Reason (suicidal, depressed etc.)
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Dates of Service: _____ # of Days _____	Where & Reason (suicidal, depressed etc.)			

Behavioral Health Symptom Checklist

Please indicate the degree to which you have experienced any of the following symptoms in the last 4 weeks.

0 = Never

1 = Occasionally

2 = Regularly

3 = Frequently

- _____ 1. Trembling, or feeling shaky
- _____ 2. Shortness of breath or smothering sensation
- _____ 3. Racing heart, heart palpitations or chest pain (circle which)
- _____ 4. Moist palms or excessive sweating
- _____ 5. Dizziness, lightheadedness, unsteady or faint (circle which)
- _____ 6. Nausea, diarrhea, or other abdominal distress (circle which)
- _____ 7. Frequent headaches or other muscle aches
- _____ 8. Startle easily
- _____ 9. Irritability (loses temper easily)
- _____ 10. Worrying a lot
- _____ 11. Trouble swallowing, "lump in throat", or choking sensation
- _____ 12. Fearful of or embarrassed by being watched or being the focus of attention
- _____ 13. Avoid talking to strangers
- _____ 14. Fear of embarrassment
- _____ 15. Persistent fear of an object (snakes) or situation (high places) considered excessive or unreasonable
- _____ 16. High levels of anxiety in the presence of an object or situation
- _____ 17. Regular and disturbing thoughts about a past traumatic experience
- _____ 18. Regular and disturbing dreams about a past traumatic experience
- _____ 19. Avoidance of thoughts feelings, or conversations associated with a traumatic experience
- _____ 20. Excessive hand washing or fear of germs
- _____ 21. Excessive checking (i.e., doors, locks, stove)
- _____ 22. Excessive need for order or neatness or counting ritual(s)
- _____ 23. Unusual and persistent sad feelings
- _____ 24. Diminished interest or participation in enjoyable or important activities
- _____ 25. Difficulty concentrating or poor memory (circle which)
- _____ 26. Tire easily or low energy level
- _____ 27. Thoughts of suicide
- _____ 28. Increased or decreased sleep (circle which): avg. hrs per night _____
- _____ 29. Feelings of hopelessness
- _____ 30. Persistent and abnormally elevated mood
- _____ 31. Over inflated feelings of self-worth
- _____ 32. Decreased need for sleep
- _____ 33. Rapid or racing thoughts
- _____ 34. Excessive involvement in pleasurable activities
- _____ 35. Excessive and/or reckless spending
- _____ 36. See or hear things that others around you are unable to perceive
- _____ 37. Hold ideas or beliefs that are not shared by others
- _____ 38. Self induced vomiting
- _____ 39. Excessive exercise
- _____ 40. Use of laxatives or diuretics to lose weight
- _____ 41. Dieting (very strict, women consuming less than 1400 daily calories or men less than 2000 calories)
- _____ 42. Careless mistakes in school work, work, or other activities
- _____ 43. Can only pay attention for short periods at school/work/home
- _____ 44. Failure to complete schoolwork, chores, duties
- _____ 45. Hyperactive: fidgets, squirms, talks excessively
- _____ 46. Acts without thinking of consequences

Drug and Alcohol History

Indicate the level of use for each substance by checking the appropriate box.

	No Use	Past use	Current Use		No Use	Past use	Current Use
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If current or past use is indicated to any of the above items complete the following questions?

Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection

Are you currently pregnant? No Yes Are you an IV drug user? No Yes

Have you ever received inpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Have you ever received outpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Are you involved in any community self-help groups such as AA No Yes

Family History

Marital status: Single Married Divorced Separated Widowed
 Living with a Significant Other but Never Married

If married: how long have you been married? _____ Spouse's age: _____

Are you presently experiencing any serious marital conflicts?

No Yes If yes, explain: _____

If you have ever been divorced: How many times were you previously married? _____

Date of divorce(s) _____

Prior to the divorce(s), how long were you married? _____

Reasons for divorce(s) _____

Living Situation: Own Home Parent's Home Relative's Home Homeless Group Home
 Residential Other _____

Household Member's Names (if client lives in more than one household list household 1 - 2)	Relation to the Client	Age	Race	Occupation or School	Level of Education
Significant Family Members/Others not listed above:	Relation to the Client	Age	Race	Occupation or School	Level of Education

Briefly describe any problem areas that occur between yourself and people you live with.

Medical History

Physician Name: No Yes _____ Phone: _____

Address: _____
Street & Number City State Zip

Date of most recent physical exam: _____ By Whom: _____

Results: _____

Immunizations - Check the immunizations for the following diseases: Chicken Pox Diphtheria German Measles
 Measles Mumps Polio Small Pox Tetanus

Drug Allergies: _____ *

List any major illness and/or operations

Have you had any medical hospitalizations in the last three years No Yes, if yes, complete below:

Hospital	City	Date	Reason

List any *current* physical concerns (e.g. high blood pressure, headaches, dizziness, etc.):

List any *past* physical concerns:

Have you ever had head trauma that resulted in loss of consciousness and/or required medical treatment? No Yes

What medications are you now taking? List all medications including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.

Prescription/Over the Counter Medication: No Yes

Out of Medication: No Yes

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Do you think these medications help you get better? N/A No Yes Unknown

Do you use caffeine? No Yes from (coffee, tea, soda) _____ Daily Use _____
 Do you use tobacco? No Yes from (cigarettes, snuff, snus) _____ Daily Use _____

Describe your appetite? Poor Appetite Average Appetite Large Appetite

Has your weight changed in the last year? No Yes If yes, by how much? _____ weight gain loss

How much sleep do you get each night? _____ When you go to bed, how long does it take you to fall asleep? _____

Do you awaken in the night and have difficulty returning to sleep? No Yes Do you awaken before you plan to get up? No Yes

Has client had any of the following symptoms in the past 60 days? Please check.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Coughing | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Tingling in Arms/Leg |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Falling | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Consciousness Loss | <input type="checkbox"/> Gait Unsteadiness | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Vision Changes |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Pulse Irregularity | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Other: _____ | | | |

Health History Questionnaire

Health History Questionnaire: Have you or any of your relatives (related by blood) had any of the following health problems? If a blood relative has had the condition, please write down the relationship to the you (parent, brother or sister, aunts/uncles, cousins, children, etc.) in the comment section.

Problem	Client			Family History	Comment (Indicate family member relationship to client)
	Now	Past	Never		
AIDS					
Alcoholism					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Brain Tumor					
Cancer					
Cirrhosis					
Depression					
Diabetes					
Drug Abuse					
Epilepsy/Seizures					
Eye Disease					
GI Problems					
Glaucoma					
Headaches					
Head Injury					
Hearing Problems					
Heart Disease					
Hepatitis					
High Blood Pressure					
Hyperactivity					
Jaundice					
Kidney Disease					
Learning Problems					
Lung Disease					
Low Blood Pressure					
Menstrual Pain					
Oral Health/Dental					
Schizophrenia					
Sexually Transmitted Disease					
Speech Problems					
Stroke					
Suicide					
Thyroid					
Tuberculosis					

If the client has had any of the above, please write the problem, what treatment was received, and when:

Problem and Treatment Received:	When:
Problem and Treatment Received:	When:

Educational History

Highest Degree attained: High School Associate Degree/2yr tech Bachelor's Degree Master's Degree Ph.D.

Highest Academic Year completed: _____ Highest Vocational Year Completed: (if applicable) _____

Type of school placement: Regular Special Education Home-Schooled Unknown

Type of Special Education Placement: None Cognitive Disability Emotional Disability
 Learning Disability Multiple Disabilities
 Other: _____

Did you have difficulties in school? No Yes. If yes, please explain

Do you have special communication needs? TTD Device Interpreter Services

Employment History

Employment Status

Employed Full Time (30 or more hours) Employed Part Time If part time, number of hours worked weekly _____
Job/Occupation: _____

Unemployed Unemployed due to disability. Date Last Worked _____

If unemployed, do you want to work? No Yes. If yes, what kind of work would you like to do? _____

Current Employment

Name of employer: _____

Job Position: _____ How long have you been in this position _____

Date Last Worked _____

Have you been disciplined by your supervisor? Yes No

Have you had frequent tardiness? Yes No

Have you had frequent absences? Yes No

Are you satisfied with your job Yes No

Family Financial History:

Amount of Monthly Income _____ Source(s) of income: _____

Loss of Income due to: _____

Financial Problems No Yes If yes, explain: _____

Military History

Are you currently in the military? No Yes If yes, what branch? _____ How long? _____

Rank: _____ What work did you do for the military? _____

Have you recently been deployed to a combat zone? No Yes If yes, have you experienced any psychological or physical difficulties because of this deployment? No Yes explain? _____

Have you ever been in the military? No Yes If yes, what branch? _____ How long? _____

Rank: _____ What work did you do for the military? _____

When were you discharged? _____ Type of discharge: _____

Have you ever been deployed to a combat zone? No Yes If yes, when? _____ Have you experienced any psychological or physical difficulties because of this deployment? No Yes explain? _____

Interests and Community Involvement

What meaningful activities, including leisure and recreational activities to you engage in?

What community activities, including volunteer work are you involved in?

What religious or spiritual activities do you participate in?

List any cultural or family traditions you have?

Legal History

Do you have a Legal Guardian/Custodian? No Yes If yes, Name: _____ Phone: _____

Civil Proceedings: _____ Current Past When? _____

Domestic Relations Court
(Custody, Protective Services, Restraining Orders): _____ Current Past When? _____

Child Support Enforcement Orders: _____

Job and Family Service Involvement with Family: _____
Caseworker assigned to Family: _____ Phone: _____

Juvenile Court Involvement (for Child Abuse, Neglect or Dependency): Current Past When? _____

Current Legal Status: None Awaiting Charges On Probation/Parole Conditional Release
 Outpatient Commitment Incarcerated
 Other: _____

Legal Charges: Juvenile No Yes If yes,
 Felony Misdemeanor Charge: _____ Current Past When? _____
 Felony Misdemeanor Charge: _____ Current Past When? _____

Legal Charges: Adult No Yes If yes,
 Felony Misdemeanor Charge: _____ Current Past When? _____
 Felony Misdemeanor Charge: _____ Current Past When? _____

Incarcerations:
From _____ To _____ Where _____ Conviction: _____
From _____ To _____ Where _____ Conviction: _____

Probation/Parole Officer: _____ Phone: _____

Print Name (Person completing questionnaire): _____ Signature: _____ Date: _____

Reviewer Name/Degree (if applicable) _____ Signature: _____ Date: _____

Comments: _____

To the best of my knowledge, all the information I have given is accurate. I understand the information contained in my chart kept at Prime Behavioral Health, LLC, may not be released to anyone without my written consent, with these exceptions:

- If the law mandates disclosure
- If you have placed yourself or someone else in clear and imminent danger
- For the purposes of therapist supervision & consultation, within the ethical guidelines of the American Counseling Association.

CLIENT'S SIGNATURE _____ DATE _____

PLEASE PRINT LAST NAME _____ FIRST NAME _____

CANCELLATIONS & MISSED APPOINTMENTS

All appointment cancellations require a **24-hour notice** or in the case of illness, a message prior to 8:00 am on the appointment day. Our voicemail is available 24 hours/day to take messages after hours or on the weekends if you need to cancel an appointment. Adequate notification respects the doctor/therapist's time as well as allows availability to others requesting services. Failure to not show at all or to give a less than 24-hour notice on cancellations will result in a \$35.00 charge which must be paid prior to scheduling another appointment. In addition, arriving late to appointments could also result in charges that would be equal to the time you kept your therapist waiting. **Insurance will not be billed for this.**

Due to the high demand for appointments, two no-show appointments in a row will result in future appointments being removed from our schedule. If you desire to return for services and this is approved by your therapist, you will need to call to schedule new appointments.

I HAVE READ THE OFFICE POLICY AND RECEIVED A COPY OR HAD ACCESS TO IT ON THE WEBSITE. I UNDERSTAND AND AGREE TO THE TERMS CONTAINED IN IT.

Client/Legal Guardian Signature

Date

Witness

Date

Prime Behavioral Health, LLC

CONSENT FOR TREATMENT AND INFORMATION SHEET

The decision to begin mental health treatment is one that may have important results for your life. Research has shown that individuals entering therapy achieve more favorable results when they have a good understanding of what to expect. We have developed this sheet to provide you with an overview, but no information sheet can answer all questions, so please feel free to ask us about any questions you have.

Individual sessions usually last 45-60 minutes providing us with time to think about what you have said, make notes, and plan your services. Your first session will usually be devoted to assessing the type and extent of the problems and concerns you have and to plan your services.

Your therapist has a responsibility to ask questions about your history, your life situation, and your current distress. Your therapist also has a responsibility to be open with you and to provide direct information about your treatment.

As a client in our office, you will also have certain responsibilities for payment and for keeping your appointments. Your most important responsibility, however, is to yourself – to work towards the goals we mutually set, and to work toward your goals both during sessions and during days between sessions. This is your time for you.

If you fail to inform our office of any change of insurance (i.e., termination of policy, addition of new policy, or change in a policy) prior to or by the effective date of the change, which results in failure of our office to be able to bill and receive payment for any charges incurred, you will be billed directly for those charges to the extent of the allowed amount for those charges by the most recent insurance policy provided to us.

There are charges which are not covered by insurance for missed appointments and late cancellations. Please refer to the Canceled and Missed Appointment Policy form for details on these charges.

Once any charge has remained on your account for 90 days, the entire outstanding balance will be forwarded to a collection agency. Any fees and/or interest added by the collection agency will be charged to you in addition to the outstanding balance which you owed to Prime Behavioral Health.

We place a high value on the confidentiality of your records. Records will be held confidential except as required by law, or as released by your written authorization. In a small number of situations, therapists are legally required to reveal information; for example, if you reveal information that indicated a clear danger of injury to yourself or others. Records may, on occasion, be reviewed for quality and appropriateness of care by the clinic or by your insurance company.

Every effort is made to answer calls during our regular office hours. If we are unable to answer or the office is closed at the time of your call, please leave a message, and we will return your call as soon as we can.

Entering psychotherapy requires a commitment of time, energy and resources, and often also requires some courage to make the first appointment. Your commitment will be honored here and you will be treated with respect. Thank you for choosing our office.

**I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO MY RESPONSIBILITIES, AND
CONSENT FOR TREATMENT.**

Signature

Printed Name of Client

Date

Prime Behavioral Health, LLC

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740-653-6500

COURT FEE SCHEDULE

- All fees charged for court activity are based on portal-to-portal travel.
- A retainer for the estimated full amount of the fee will be required one week before a court appearance.
- If actual fees exceed estimated fees, clients will be responsible for the remainder of the fee within one week of rendered services.
- Fees will be assessed in four-hour blocks.

Fee Rates

- Fees for court related activities requested more than two weeks in advance = \$120 *per hour* (Minimum = \$480)
- Fees for court related activities requested less than two weeks in advance = \$240 *per hour* (Minimum - \$960)

Cancellation Policy

- If request for court related activities is cancelled at least 2 weeks prior to scheduled appearance, the client will be entitled to a full refund minus any time the counselor used for preparation.
- If request for court related activities is cancelled at least 1 week prior to scheduled appearance, the client will be entitled to a 50% refund minus any time the counselor used for preparation.
- No refund will be given for cancellations that occur within the week of the scheduled activity.
- If a counselor is subpoenaed for court related activity and the subpoena is cancelled, regardless of retainer not being submitted, the client will be responsible for the initial requested fee.

Consideration for modification of this fee schedule will be made on a case-by-case basis.

Client Signature

Date

Your signature states that you are aware of this policy. *Please sign even if you feel that this will not apply to your situation.*

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**FEE SCHEDULE
All Counselors**

Initial Session	\$160
Office Visit ~60 Min	\$150
Office Visit ~45 Min	\$120
Office Visit ~30 Min	\$ 80
Family Counseling ~45 Min	\$130

I have read and understand the Financial Policy and office procedures at Prime Behavioral Health, LLC. I agree to the cancellation/reschedule policy. I further understand I will need to make my co-pay at each visit. I acknowledge that I have either received a copy of this policy or have it available to me from the website at www.carebyprime.com

Client Name (please print)

Date

Client Signature

Revised 10/15

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We like to keep your information current. Please list anyone to whom we may speak or leave a message in regard to appointments or payments/billing along with their relationship to you.

NAME

RELATIONSHIP

_____	_____
_____	_____
_____	_____

Signature _____

Date _____

APPOINTMENT REMINDERS BY PHONE, TEXT AND/OR EMAIL

We can now send you appointment reminders by email or SMS text. **PLEASE READ THE FOLLOWING:** The appointment reminder will include only the date and time of your appointment and your service provider's name. We will not encrypt the messages. Health care information sent by regular e-mail or SMS text could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email or SMS text, please confirm that you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

Failure to receive appointment reminder by call, SMS text, or email does not release the responsible party of any responsibility for a charge that may be incurred for a missed appointment or late cancellation (less than 24 hours). You are responsible for keeping the card that is available for you at the window when you schedule your appointments or for appointments made by phone.

By checking a box below that enables E-mail reminders or SMS text reminders, and entering an email address or phone number, you acknowledge that you have received the information shown above and acknowledge your consent.

- Enable email reminders
- Enable SMS text reminders
- Phone call only

Recipient email:

Recipient Mobile Number:

Prime Behavioral Health

NOTICE FOR ACCOUNTS WITH BALANCES DUE

Please take note of our new policy regarding our scheduling policy due to outstanding balances.

Beginning immediately, if you have an account with balances from unpaid copays, fees for missed/late canceled appointments, and coinsurance and/or deductibles for claims that HAVE FINISHED PROCESSING through your insurance, the clerical staff have been advised to not schedule any new appointments until the balance is paid in full. Please keep 3 appointments booked at all times so that you will still have at least 2 appointments on the books. We will not cancel any appointments already on the schedule. Please pay the amount requested when you check in for your appointments to avoid this issue. We diligently try to ask for the proper amount we expect to be due after your insurance processes your claim to keep you from getting behind. We adjust the balance accordingly, when needed, after we receive the final decision from your insurance. However, policies with co-pays do require the payment at the time of service. Payment can be made in person, over the phone, or via our website or QR codes on our statements.

We would encourage you to keep a credit/debit card on file with our office and sign to give us permission to charge your card for balances due (as needed) to be sure that there is no disruption to your care. Ask the receptionist about this option.

If you have questions or concerns, please feel free to discuss this with us.

Name

Date

January 11, 2024