PLEASE COMPLETE ALL PAPERWORK AND RETURN TO OUR OFFICE:

The Psychology Clinic
2000 Southwood Drive
Lake Charles, LA 70605

THANK YOU FOR CONTACTING OUR OFFICE

WE HAVE SET YOUR APPOINTMENT FOR:

PLEASE COMPLETE AND RETURN THE ENCLOSED FORMS TO OUR OFFICE BY:

IF WE ARE HOLDING AN APPOINMENT TIME AND DON'T RECEIVE THE FORMS 48 HOURS IN ADVANCE OF THE APPOINTMENT TIME WE'LL CANCEL YOUR APPOINTMENT. UPON RECIEIVING YOUR PAPER WORK WE'LL THEN CONTACT YOU TO RESCHEDULE.

PLEASE ARRIVE 15 MINUTES EARLY SO WE CAN MAKE COPIES OF INSURANCE CARDS.

AGREEMENT TO PAY
ONCE AN APPOINTMENT IS SCHEDULED I UNDERSTAND IT'S MY RESPONSIBILITY TO NOTIFY THE OFFICE ABOVE 24 HOURS BEFORE THE SCHEDULED APPOINTMENT TIME IF I CHOOSE TO NOT KEEP THE APPOINTMENT OR IF I NEED TO RESCHEDULE DUE TO UNFORSEEN DIFFICULTIES. I AGREE TO PAY THE NON-REFUNDABLE FEE OF $50 (LCSW/LPC) or $75 (Ph.D) IF I GIVE LESS THAN 24 HOURS NOTICE OR IF I DO NOT SHOW UP FOR MY SCHEDULED APPOINTMENT.

_____ _____
(Print Name) (Date)

_____ _____
(Signature of Responsible Party) (Date)

Insurance Information

Clinician: Appointment Date:

Patient Name: DOB: SSN:

Patient Address: City: State: Zip:

Phone: (_____) _____ Alternate Phone: (_____) _____

Insurance Company:_____ Phone: (_____)_____

Subscriber ID: _____ Group No: _____

Subscriber's Name: _____ DOB: _____ SSN: _____-_____-_____

Subscriber's Address: _____ City, State, Zip: _____

Phone: (_____) _____ Alternate Phone: (_____) _____

Employer:_____

OFFICE USE ONLY
Effective Date:_____

Co-Pay/Co-Insurance: _____

Deductible:_____ Deductible Met?:_____

No. of Visits:_____

Authorization:_____

Out of Pocket _____

Psychological Testing Covered the Same?_____

Mail Claims To:

_____

_____

Assignment of Insurance Benefits
Acknowledgement of Indebtedness
& Consent to Release Information

Insured Patient: _____
(Please Print)

For services provided, I hereby irrevocably assign and transfer to The Psychology Clinic of Lake Charles, LA, my rights and interest in all benefits due under the applied insurance policy or in my rights against any third party who might be held liable for the services described in the statements rendered by the hospital.

I hereby consent that The Psychology Clinic may release information concerning the above party and furnish copies of my records if requested by the insurance company. I hereby release The Psychology Clinic from legal responsibility or liability for furnishing such records or information to the extent indicated and authorized herein. I acknowledge that the Law of the State of Louisiana controls and governs the interpretation of this agreement.

I understand that I am personally and directly responsible for all bills submitted by The Psychology Clinic for professional services rendered to me and that I have the primary duty and obligation to pay my doctor for these services, notwithstanding any contract that I may have with any third party, such as an insurance company, employer, union or the government.

_____ _____ _____
Date Signature Relationship to Patient

Person Responsible for Payment

I understand that I am personally and directly responsible for all bills submitted by The Psychology Clinic of Lake Charles for professional services rendered to me and that I have the primary duty and obligation to pay my doctor for these services, notwithstanding any contract that I may have with any third party, such as an insurance company, employer, union or the government.

I hereby stipulate and agree to pay all cost of collections or attorney fees and court fees should it become necessary to resort to court action or turn my account over to a collection agency.

_____ _____
Date Signature

In order to control our costs of billing, office visits are to be paid at the time the service is rendered.