

# Welcome

*Please fill out the following and return.*

## Section I – Patient Information

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
Marital Status \_\_\_\_\_ Gender  Male  Female  
Employer or School \_\_\_\_\_  
Referred by \_\_\_\_\_

## Section II – Insured Information

Patient Relationship to Insured:  Self  Spouse  Child  Other  
If “Patient Relationship to Insured” is other than “Self”, then please complete the following. If patient is the insured, go to Section III

Insured’s Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
Marital Status \_\_\_\_\_ Gender  Male  Female  
Employer or School \_\_\_\_\_  
Employment Status \_\_\_\_\_

## Section III – Insurance Policy Information

Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Plan Name \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

*Over, please...*

**(630) 377-3535**

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## For Your Review and Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment.
- Obtain payment from third party payers.

I am aware that the Notice of Privacy Practices is posted on your web site and in your office for my review of a more complete description of the uses and disclosures of my health information. I have been given the right to review this Notice prior to signing this consent. I understand that David Goodman, Ph.D. Psychologist & Associates has the right to change its Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff will inform you of the financial payment policies of this office. I understand that although my insurance may pay a portion of the cost of the professional services received in this office, I am ultimately responsible for complete payment of the charges. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. Coverage is preverified and you will be asked to pay any unmet deductible, non-covered services and co-payments. We accept payment in the form of cash, check, or credit card (Visa, MasterCard or Discover card only, not American Express). In the event the account is turned over to a collection agency, a collection fee of 25% of the outstanding balance will be added to your account to cover the cost of collection.

I authorize the release of medical information, if needed, to process insurance claims. I also authorize payment of benefits to the provider.

I understand that should I at any time during the course of treatment need to cancel or change an appointment time, I will need to do so within 24 hours of the appointment time, unless an emergency situation arises or I will be charged for the missed appointment since it is reserved for me and, without sufficient notice, is unavailable to anyone else.

Your signature below signifies your understanding, agreement, and willingness to comply with the above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Responsible Party (If different than client)

\_\_\_\_\_  
Date

*Please sign and return to office.*

DAVID GOODMAN, Ph.D.  
**PSYCHOLOGIST ASSOCIATES**  
*Caring and Effective Solutions*