Patient Information and Professional Services Agreement

Original Intake_____Updated Intake_____ Provider Name_____ Today's Date:_____

Patient Last Name:_____First:_____Middle:_____

Birth Date: _____ Social Security #: _____ Gender: ❒ M ❒ F

Primary Phone: (___)_____-_____ Secondary Phone: (___)_____-_____

E-mail Address:_____

Address: _____ Apt. #:_____

City: _____State: _____Zip Code: _____

Responsible Party if patient not 18: _____Phone: (_____)_____-_____

Address:_____❒ Same as above

City: _____State: _____Zip Code: _____

Emergency Contact: _____Ph:_____

Address: _____Email:_____

City: _____State: _____Zip Code: _____

Insurance: Does your insurance require a "referral" or "pre-auth" PRIOR to first visit? ❒ Yes ❒ No

Insurance Company: _____ Copay Amount: _____

Insurance Phone #: _____ Group #: _____ ID #: _____

Policy Holder Name: _____ Social Security #: _____

Relation to Patient: _____ Date of Birth: _____ Gender: ❒ M ❒ F

Address (if different from patient): _____

Effective Date: _____Policy Holder Employed by:_____

Secondary Insurance: Do you have a second insurance that covers health care? ❒ Yes ❒ **N**o
Are your services to be paid by Worker's Comp or Auto Accident Insurance? ❒ Yes ❒ No
Are you using an EAP Employee Assistance Program to pay for services: ❒ Yes ❒ No

If YES to any of the above, request and complete additional insurance information form.

Medicare Information:
If insured with Medicare, how do you qualify? ❒ Retirement ❒ Long-term Disability ❒ ESRD
Do you currently have a spouse that is employed? ❒ Yes ❒ No

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If you marked Yes above, are there more than 20 employees at their place of work? ❒ Yes ❒ No

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Acknowledgement. ***I understand that the clinician providing services to me is independent from CPS and that CPS provides billing and scheduling services for the professional.***

Insurance Benefits. I understand that it is my responsibility to check with my insurance company regarding my benefits before receiving services and that I should advise CPS of any required authorization procedures.

Fees, Payment, and Insurance Billing. I agree to pay my copay, contracted rate, or the full fee if I am a self-pay client or if my insurance fails to pay. Appointments canceled less than 24 hours in advance will result in a charge of $60 which cannot be billed to insurance. Additional fees may be billed for services such as written reports, completion of paperwork, etc. ***Collections Fee.*** A collections fee of 35% of my unpaid balance will be added to the unpaid amount over due. Services may be denied, if payments are not received on the day of service.

Authorizations and Release of Information. ***P***rofessional staff at CPS may exchange information relevant to my care and may share information with my Primary Care Physician, and your health care insurers. I understand that my health care provider is required by law to report any threat to human life or any suspicion of child abuse. I also understand that it may be necessary to furnish information to a court of law if a subpoena is issued (in cases of child custody, accidents, divorce, or otherwise).

Consent for Treatment. While most people benefit by participating in mental health services, in some cases symptoms or problems may worsen. In signing for services for a minor, I certify that I am the legal guardian and I have the legal right to approve of the evaluation, treatment, and release of information. As the legal guardian, I understand that I (or another guardian) must be present for services to be rendered with an under aged child.

Emergencies. Please call 911 or go to a local emergency room. CPS provides its services by appointment only. If you need to reach your clinician after hours, please call (801) 483-1600, option 9 and wait for a representative. Prescription medication interaction and side effects information is available through your pharmacy.

Program Rules and Grievances . I understand that weapons or pets unless certified as support animals and vested are not allowed in the CPS facility. ***Grievance Policy. To file a grievance*** contact the CPS staff representative and/or the CEO. Then the matter will be reviewed and you will be notified of CPS' resolution.

Treatment and Services. I understand that CPS offers a variety of outpatient mental health services, including but not limited to psychotherapy, psychiatric medication management, and psychological testing. I understand that I can expect outpatient mental health services as outlined in our list of services; confidentiality and secure records keeping; professionalism and competency from providers and office staff; scheduling support; referrals to outside sources if necessary and in keeping with my treatment plan; and prescription refill support if CPS is given 5 days advance notice.

I have been given information regarding behavioral health diagnosis and treatment and best practices as described by the American Psychiatric Association section on Patients and Families; information regarding local support groups, information about CPS privacy policies and client rights, and this Patient Services Agreement.

I understand that the services provided are ongoing and scheduled on an as needed basis. CPS does not document a formal discharge unless requested or required by an agency. Services may end voluntarily and resume at any time.

By virtue of my signature below, I understand the risks and responsibilities noted above and agree to the conditions implied or stated above.

Signature of Responsible Party: _____ **Date:** _____

Please Print Name of Responsible Party: _____

Please Print Name of Patient: _____ **DOB:** _____