Center of Psychological Effectiveness, Inc.
7390 NW 5th Street, Suite 5, Plantation, FL 33317 * Phone (954) 583-8831

APPLICATION FOR SERVICES AND FINANCIAL POLICY

Thank you for selecting our therapist team! We will strive to provide you with the best possible care. To help us meet your entire healthcare needs, please complete this form in ink. If you have any questions or need assistance, please ask us, we will be happy to help you.

Referred By: _____ **Date:** _____

Patient Name: _____

Date of Birth: _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Initial if OK to send mail to this address: _____ **(Initials)**

If no, where may we send mail? **Address:** _____

City/State/Zip: _____

Home Phone: _____ **Initial if OK to leave message:** _____ **(Initials)**

Work Phone: _____ **Initial if OK to leave message:** _____ **(Initials)**

Cell Phone: _____ **Initial if OK to leave message:** _____ **(Initials)**

Email: _____ **Initial if OK to email:** _____ **(Initials)**

Occupation: _____ **Place of Employment:** _____

Current Marital Status: (check one) ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Single**
☐ **Widowed** ☐ **Significant Other/Domestic Partner**

Emergency Contact Name: _____ **Relation to You:** _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

Initial if OK to contact Emergency Contact in case of emergency: _____ **(Initials)**

Primary Care Physician: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Previous mental health contact for self or family members: _____

Current Medications:	**Dose:**	**Prescribed By:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

There is a possibility that my case will involve court proceedings: (check one) ☐**Yes** ☐**No**

(Over Please)

I authorize the release of my specified mailing address/e-mail address to allow me to receive the **FREE** newsletter **"Solutions.not talk!"** from the Center of Psychological Effectiveness, Inc.

Signature: _____ Date: _____

I hereby apply and consent to psychological therapy, consultation, and/or testing. I understand it is my responsibility to cooperate with treatment. Your signature here certifies your consent that we may use/share your Protected Health Information as described in the HIPAA PRIVACY NOTICE you have received. I consent to the electronic storage of my medical records.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

I authorize payment of medical benefits to the Center of Psychological Effectiveness, Inc., for services rendered. If a problem occurs with the insurance company regarding payment of medical benefits, the patient is responsible for payment of the medical benefits for services rendered in our office. All follow-ups with the insurance company are the responsibility of the patient.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Charges for services are due and payable at the time services are rendered, unless prior arrangements have been made with the therapist. If you have health insurance, it should be understood that this is an agreement between you and your insurance company to pay you certain amounts for medical care. Your therapist's bill is an agreement between you and your therapist. You are responsible for payment of your bill, regardless of the status of your insurance claim. Insurance companies have a schedule of fees, which they will pay. Your therapist's fees may be more or less than this actual schedule. If you fail to meet your financial responsibilities, your account may be turned over to a collection agency or the appropriate court. I hereby give my consent to release necessary information for taking such action. The patient will be responsible for any fees or expenses incurred because of collection or court actions. If a check is found to have insufficient funds, there is a thirty dollar reprocessing fee.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Because time has been reserved exclusively for me and/or family member(s), I understand that I am required to provide at least forty-eight (48) hours advance notice if unable to keep scheduled appointment. **In the event that I do not provide the forty-eight (48) hours notice prior to canceling, I am financially responsible for the reserved appointment at the rate of fifty ($50.00) dollars.**
I hereby assume financial responsibility for all charges that may be incurred for treatment rendered to myself and/or my family member(s). In understand the above described financial policy. I have also read and understand the Patient's Rights and Responsibilities and the availability of the HIPAA Notice of Privacy Policies and consent to the limitations of confidentiality as a condition of receiving services. I received a copy to retain for my records.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Witness: _____ Date: _____