PLEASE COMPLETE

Below you will find a patient information sheet which provides our office with useful information that is helpful to our staff in contacting you, processing your billing and notifying you in case of office closing, etc.

Patient Information Sheet

Client Name:_____Maiden Name:_____

Address:_____Date of Birth:_____

City/State/Zip:_____Length of time there:_____

Home Phone:_____Day or Work Phone:_____SS#:_____

Employed with:_____Length of Employment:_____

Closest Relative (not spouse):_____Relation:_____Phone:_____

Referral Source:_____

Marital Status: _____Married (living with spouse) _____Married (not living with spouse)
_____Legally Divorced _____Single
_____Widowed _____Legally Separated

**May we contact spouse regarding appointments?_____

Spouse Name:_____Maiden Name:_____Date of Birth:_____

Complete Address:_____SS#:_____

Telephone:_____Work or Day Phone:_____Job Title:_____

Employed with:_____Length of Employment:_____

Medical Information

Family Physician:_____Medical Insurance:_____Subscriber:_____

Insurance ID#:_____Group#:_____Effective:_____

Pharmacy:_____Address:_____Phone:_____

Responsible Party in case of emergency:_____Relation:_____Phone:_____

A **48 hour cancellation notification is required.** There will be a late cancellation fee ($65.00) for appointments cancelled without at least **48 hours notice**. There is a missed appointment fee ($85.00) for appointments which are not kept without any notice. These fees are not billable to any insurance carrier. For any reason, should your bank return a check to our office, the check amount plus a $25.00 handling fee will be charged to your account. If for any reason, your account is turned over to our collection agency or attorney, you are responsible for all fees.

Payment Plan (if not covered by insurance): Check/Cash at the time of service_____Other_____

If Payment Plan, approved by Business Manager?_____

I have read the Office Policies accompanying this form: Yes_____No_____

Signature_____ Date_____

Family Counseling Associates
884 Brighton Road
Tonawanda, NY 14150
836-9460

REMINDER OF MISSED APPOINTMENT AND LATE CANCELLATION FEE POLICIES

Our practice requires that in the event you have to cancel an appointment you must notify us **(48 hours) in advance**. There is a late cancellation fee ($65.00) for appointments cancelled with less than 48 hours notice and a missed appointment fee ($85.00) fee for appointments which are missed with no contact in advance, neither of these fees are insurance reimbursable.

We would like to emphasize that there are generally no exceptions to the above policy. The policy applies even if there is a good reason, such as an emergency that requires you to cancel your appointment.

On the other hand, we do have procedures that may, in some instances, permit you to avoid such charges. Specifically, if you do cancel with less than 48 hours notice, we do try to find someone to take your cancelled appointment. If we are successful, we do not charge the late cancellation fee. If we are able to reschedule your appointment within six days, there is no late cancellation fee or missed appointment fee charged providing you attend the rescheduled appointment. Finally, if there is a snow emergency and the police announce a driving ban, and you call in advance of your appointment to cancel, the late cancellation will be accepted.

EMERGENCY PROCEDURES

In case of a psychiatric emergency, you are urged to call your therapist. The process for doing so is as follows:

If you need to call during business hours, call 836-9460. Inform the secretary of the emergency and the office staff will contact your therapist of the therapist on call.

If an emergency arises after business hours, call 836-9460 and leave a message with the answering service. The service will contact your therapist or the therapist on call.

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(716) 836-9460

A WORD ABOUT CONFIDENTIALITY

If you are an HMO or Managed Care subscriber, certain rules pertaining to confidentiality may apply to your record. Your insurance company may ask to review your file or ask us to submit information regarding your case when making a determination about approval for treatment sessions or in the course of routine Quality Assurance review. Health Maintenance Organizations also require coordination of care between your primary car physicians and your therapist. Typically, this involves providing your primary care physician with a brief summary of your treatment and progress.

If you have any questions about these requirements, please feel free to speak with your therapist about them. You will find the therapist to be open to your questions and helpful in understanding the need for these requirements. Please sign in the space marked below to indicate your informed consent to these requirements.

Name_____ Date_____

_____
Signature of Parent or Legal Guardian if under the age of seventeen (17).