Child and Adolescent Psychology Professionals

Registration Form

Date: ____________________________

Child's name: ________________________________ Sex: _____ Age: _____ DOB: ________

Social Security Number: _______________________

Parent/Legal Guardian: __________________________________ Relationship: _____________

Social Security Number: _________________________

Marital status: __________________ Custody status (if divorced or separated): ______________

Address: ____

Primary Phone: __________________________ 2nd Phone: ____________________________

Email: ______________________________________

(Please indicate if phone numbers are Home, Work, and/or Cell)

Parent/Legal Guardian: __________________________________ Relationship: _____________

Social Security Number: _________________________

Marital status: __________________ Custody status (if divorced or separated): ______________

Address: ____

Primary Phone: __________________________ 2nd Phone: ____________________________

Email: ______________________________________

(Please indicate if phone numbers are Home, Work, and/or Cell)

EMERGENCY CONTACT: ___________________________ Relationship: _______________

Phone number(s): ____

Divorced/Separated Families: As children are part of a family system, decisions about psychological, medical, and/or educational care, etc. must be made by the child's legal guardian(s), who must be physically present to provide consent, have an opportunity to be fully informed of the treatment process, be provided with an opportunity to ask questions, and in order for identity to be verified. In the unfortunate event of a parental separation or divorce, both parents MUST consent, in writing, to treatment. Both parents are invited and encouraged (as they are able) to participate in the process of treatment. If one parent retains sole legal custody, this parent MUST provide legal documentation of this in order for assessment to proceed. In the case of joint custody, both parents MUST consent to the assessment. Both parents, regardless of custody, have a legal right to records (see Arizona Revised Statute 25-403.06).

Financial Agreement

<u>**Payment/Financial Responsibility**</u>**:** Payment is collected at the time of your appointment. If you are paying privately, payment is collected at the time of your appointment. If your insurance is being billed, your co-pay or co-insurance (if required) will be collected at the time of your appointment. We bill only insurance we are contracted with. Furthermore, it is your responsibility to follow up with the insurance company regarding your insurance benefits, including what your insurance will and will not pay for. We assume no responsibility for lack of knowledge regarding your insurance benefits. You are responsible for any unpaid charge(s) as determined by your insurance company regardless of cause. You are responsible for 100% of fees not paid by your insurance within 90 days of nonpayment. We reserve the right to change fees with 30 days written notice. Refunds are not made after the services have been rendered. It is your responsibility to provide notification if problems arise during the course of treatment regarding your ability to make timely payments. In circumstances of unusual financial hardship, fees adjustments or a payment installation plan can be negotiated.

☐ Private Pay (see Fee Schedule)

☐ Contracted Insurance:

By completing the information below, you assign your insurance benefits to be paid directly to Gina De Simone, Psy.D. PLLC. You also authorize Dr. De Simone to release any information, which may be needed for processing all of claims; certification/case management/quality improvement; and/or information related to the benefits of your health plan and in accordance with HIPPA regulations. Furthermore, it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit.

Insurance Company: ________________________________ Phone: ________________

Employer: ____________________________ Employee SS#: ____________________

ID#: _______________________________ Group#: ____________________________

Employee/Insured's name: ______________________________ DOB: _____________

Insurance Mailing Address: ____

<u>**Cancelled/Missed Appointments**</u>**: Cancellations must be made at least 24 hours in advance. You will be billed according to the Fee Schedule. Waiver of the late cancellation fee will be made on a case by case basis.**

Fee Schedule

<u>Psychotherapy</u>	
Diagnostic Intake	$200
Individual Psychotherapy	$75
Individual Psychotherapy	$125
Individual Psychotherapy	$150
Conjoint/Family Psychotherapy	$150
Telephone consultation (> 15 min) (e. g. client, parent, school, teacher, or other professional)	$150/hour
Missed appointment (full)/late cancellation: 2nd occurrence	$75.00 per
Missed appointment (full)/late cancellation: 3rd occurrence+	$150 per
Letter (brief)	$25
Letter/documentation (extensive: >15 min)	$150/hour
Records Review	$150/hour
Personality testing	$50

<u>Psychological testing</u>	
Psychoeducational/Neuropsychological testing	Age 6-7: ____ $1350 Age 8-16: ____ $1600
Psychological testing	$1200
Additional testing time	$150/hour
School consultation	$150/hour
Letter (brief)	$25
Letter/documentation (extensive: >15 min)	$150/hour
Records Review	$150/hour
Late cancellation (<24 hours)	50% of scheduled service
Records request over 25 pages (26+)	$.25/page
Other: ______________________________	___________

PLEASE NOTE: Fees associated with phone consultations, missed/late cancelled appointments, letters/documentation, records requests, or any service beyond scheduled psychotherapy sessions are billed according to the above schedule of fees and are not necessarily covered by insurance. You are 100% responsible for fees incurred for services rendered that are not covered by your insurance and have not been paid in 90 days. Thank you.

I understand and agree to <u>all</u> of the terms and conditions above:

________________________________ ________________________________

Signature of legal guardian Date Signature of legal guardian Date