Gonski Counseling Services

REGISTRATION FORM (Please Print) **Melissa Gonski, MA, LCPC**

Today's date:				Primary Care Physician:		
PATIENT INFORMATION						
Client's **Last Name**: **First:** **Middle**:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security no.:	**Birth date:** / /	Age:	Sex: ❑ M ❑ F	
Street address:		E-mail Address:		Home phone #: ( )		
City:	State:	ZIP Code:		Cell phone #: ( )		
Occupation:	Employer:			Work phone #: ( )		
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital	
❑ Family	❑ Friend	❑ Website/Internet	❑ Yellow Pages	❑ Other		
INSURANCE INFORMATION						
(Please give your insurance card to the therapist.)						
Person responsible for account:	Birth date: / /	Address (if different):		Home phone #: ( )		
Occupation:	Employer:	Employer address:		Employer phone #: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No Self-Pay						
Primary Insurance Company:						
Subscriber's Name:	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group #:**	**Policy #:**	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:		Group #:	Policy #:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Cell/Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Gonski Counseling Services. I understand that I am financially responsible for any balance not paid by insurance. I also authorize Gonski Counseling Services or insurance company to release any information required to process my claims.

Signature_____ Date _____

Gonski Counseling Services

FINANCIAL TERMS OF TREATMENT

1. 48 hours notice of cancellation is required. If cancellation is made after this time you will be charged a cancellation fee in the amount of $130. In case of an emergency, death in the family, hospitalization, illness, etc., please speak with your therapist regarding this fee.
2. The undersigned agrees that, in consideration of the services to be rendered to the patient, he/she agrees to pay Gonski Counseling Services in accordance with the regular fees and terms as outlined.
3. Any insurance claim submitted to an insurance carrier that is denied due to a billing error will be corrected and resubmitted at the expense of Gonski Counseling Services. Any insurance claim denied due to a patient/guarantor error (incorrect policy information, etc.) will be subject to a claim denial fee in the amount of $5.00 per claim. If denied claim is correctable and payable upon resubmit the denial fee will be waived. Claim will be subject to a claim resubmit fee in the amount of $2.50 per claim.
4. Should the account be referred to an agency or attorney for collection, the undersigned will pay for all attorney fees and will be responsible for all collection expenses. The undersigned shall also be held responsible for all interest after 60 days, at the rate of 1.5% of the unpaid monthly balance.
5. In the instance of failure to comply with these obligations, each consents to the disclosure of their identity and other necessary information relating to the services rendered to the patient by the attending counselor, clinic, or attorney for the purpose of enforcing the patient's or guarantor's obligations to the attending counselor or collection agency or attorney. Such disclosure or redisclosure shall not be deemed to be a breach of the patient's confidentiality by the attending counselor/psychotherapist or clinic.

I have read and understand the above information and agree to these conditions.

Signature of patient or responsible party/guarantor _____ Date _____

AUTHORIZATION AND RELEASE

I authorize Gonski Counseling Services to release any information including the diagnosis and the records of any treatment of examination required to the above named patient during the period of such care to the third party payor for the sole purpose of obtaining payment for services rendered to the patient by Gonski Counseling Services.

I authorize and request that my insurance company pay directly to Gonski Counseling Services all insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual fee for service billed. I agree to be responsible for all fees for service not paid by my insurance carrier for services rendered on behalf or myself, or my dependents, unless prohibited by contract.

Signature of patient or responsible party/guarantor _____ Date _____