Studio City Clinical Associates

PATIENT INFORMATION

Name:_____ Age:_____
Last, First MI

Street Address:_____

City, State:_____ Zip:_____

Phone:_____ Cell:_____ E-mail:_____

DOB_____ Male/Female SS#_____ Marital Status:_____

Employer_____ Work Phone: _____

RESPONSIBLE PARTY INFORMATION (person who is financially responsible for co-pays & deductibles due)

Name:_____ Age:_____
Last, First MI

Street Address:_____

City, State:_____ Zip:_____

Phone:_____ Cell:_____ E-mail:_____

DOB_____ Male/Female SS#_____ Marital Status:_____

Employer_____ Work Phone: _____

INSURANCE INFORMATION - Insurance Prior Authorization Number: (see note below)_____

Primary Ins:_____ Phone # for mental health: _____

Subscriber name:_____ SS#_____ DOB_____

Employer_____ Work Phone: _____

Relation to patient:_____ ID/Membership #:_____ Group #:_____

Secondary Ins:_____ Phone # for mental health: _____

Subscriber name:_____ SS#_____ DOB_____

Employer_____ Work Phone: _____

Relation to patient:_____ ID/Membership #:_____ Group #:_____

REFERRED BY:_____

I hereby authorize Karen Chambre, LCSW to release any information requested by Reliable MH Billing Services that is needed to bill the above named insurance companies and/or responsible party directly. I hereby authorize Karen Chambre, LCSW and Reliable MH Billing Services to release any information requested by the above named insurance companies that is needed to check my insurance benefits and to submit claims. I authorize any insurance benefits to pay directly to Karen Chambre, LCSW.

***PLEASE READ**: I understand that I may need prior authorization from my insurance company to see this provider and that it is my responsibility to get the authorization prior to, or on the day of my first appointment with this provider. If an authorization is required by my insurance company and I do not obtain it, I understand that I am financially responsible for the services not covered by my insurance company. Furthermore, I understand that I am financially responsible for the services with Karen Chambre, LCSW should my insurance company deny my claims submitted by Reliable MH Billing Services.*

I affirm the above to be true and give my consent for treatment.

_____ _____
Signature Date

Please scan or take a picture of the front and back of your insurance card and fax or email this form and the image of your card(s) to Reliable MH Billing Services. Fax: 760-919-3132 Email: Julie@ReliableMHBillingServices.com

Studio City Clinical Associates

Information Sheet

Your Name _____

Your Address _____

City _____ Zip _____

Home # ____ - ____ - _____ Business # ____ - ____ - _____ Cell # ____ - ____ -_____

E-mail address_____Occupation _____

Place of Business _____

Social Security Number _____ -- _____ -- _____ Date of Birth ____ / ____ / ____

Please list the persons living in your household

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I was referred by: _____

Do you have any health problems? If so, please explain: _____

_____

Please list any medications you are currently taking: _____

_____

How often do you use drugs or alcohol? _____

All information disclosed to the therapist will be held as confidential. Confidentiality, however, does not extend to bodily harm to self or others, or the abuse of a child. I understand that in the above instances the therapist is required by law to report the situation to the appropriate authorities. Payment is due at the end of each session. If payment is not received at the end of the session, I understand that I will be billed monthly. (Prompt payment is greatly appreciated.)

By signing below, I acknowledge the 24-hour cancellation policy which states: if an appointment needs to be rescheduled or canceled, I will notify this office 24-hours in advance (emergencies, illnesses are the exemption.) I understand that missed appointments cannot be charged to the insurance company and, if a 24-hour notice is not provided, I understand that I will be personally responsible for the charges of the missed session.

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Release of Information HIPAA Form

I authorize the release of information for claims, certifications/case management/quality improvement, and other purposes related to benefits of my Health Plan I authorize my Health Plan to pay my therapist directly for treatment.

Initial here, or write “not authorized” if you do not want your insurance billed:

_____

Consent for Treatment

I authorize and request my therapist to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures that now, or during the course of my treatment become advisable. I understand the

purpose of these procedures will be explained to me upon my request, and are outlined above in this document, and that they are subject to my agreement.

Patient Signature Date

_____ _____