Karen Johnston Gieseke, Ph.D. and Associates
42 Valley Rd. #3C
Middletown, RI 02842
401-842-0009

Date_____

Home phone_____

PATIENT INFORMATION

Name_____
(last) (first) (Middle)
Sex_____M_____F Age_____ Birthdate_____
Home Address_____
Email address:_____
Person Financially Responsible_____Cell phone_____
Work phone_____
Whom may we thank for referring you?_____

INSURANCE COVERAGE

Insured's name_____

Address (if different from patient's)_____
_____
Home phone (if different)_____work phone_____
Employer_____
Social Security Number_____ Birthdate_____
Insurance Plan Name_____ phone number_____
Insurance Plan Address_____
Group#_____Policy #_____
Emergency contact person, address_____
phone_____

RELEASE AND ASSIGNMENT

This information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my insurance status. I certify that _____is covered by insurance with _____and assign directly to Dr. Gieseke all insurance benefits for services provided. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signed_____Date_____

I **allow/not allow** Dr Gieseke and Associates to contact my primary care physician_____

Signed_____Date_____

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Dear New Client,

Welcome to my practice! Please carefully read the following information and sign below. It is important that the financial issues be clarified before we work together, so you do not have to be concerned with these at a later date.

Payment Information

Individual and family therapy are provided at a rate of $160.00-$180.00 per 45 minute interval, unless you are using insurance coverage with which I have a contract. In that case, a discounted amount will be charged to your insurance and your copayment will be accepted at the time of the visit. For all other insurance, the amount must be paid in full until reimbursement rates are established and all deductibles have been met. If you are unsure what portion of these charges your insurance policy will cover, please contact your insurance company or consult the literature provided by your employer or insurance company. Please check your coverage as soon as possible to avoid being surprised by receiving less reimbursement than you expected. ***Any balance not paid by your insurance company is your responsibility.***

Please have your payment ready at the start of the appointment, which allows us to focus on treatment, not payments. Checks should be made out to Karen J. Gieseke, Ph.D. As a courtesy to you, I will file insurance claims as quickly as possible so that you may be promptly reimbursed for any overpayments you have made at this office. Insurance will be billed based on the information provided at the first visit. Any changes in coverage, address changes, or other changes should be reported as soon as possible. The office manager handles all billing.

Canceling Appointments

Please make note of all your appointments. **Appointments not canceled at least 24 hours prior to the scheduled visit will be billed to you at a cost of $50.00.** Please be aware that your insurance will not pay for missed appointments. This is necessary to keep our business running. As you may be aware, we have set aside a considerable amount of time just for you, and when an appointment is cancelled without notice we are unable to give that time to anyone else who may need it. With prior warning, we are often able to fill the vacant time with another client who wishes to be seen.

Emergencies

This office is not readily equipped for emergency services. However, in the event of an emergency, you may try to reach us by pager or cellular phone, and we make every attempt to be available to our clients. However, in the unlikely event that my colleagues or I cannot be reached, please go to the nearest emergency room. If we are out of the area or on vacation, another provider will be arranged to accept all emergency calls.

Authorization to bill insurance

I authorize the release of any medical information necessary to process this claim and request the payment of any commercial insurance carrier benefits either to myself or to the provider or service. My signature below indicates that I have read and understood the above policies.

I agree to these terms:_____ Date:_____

Collection of Deductible/Coinsurance/Copayment Contract

Client's Name:_____ Client's DOB___/___/___

Client's Health Plan: _____

Client's ID Number: _____

Client's Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Dear Client,

We have verified with your insurance carrier that your insurance coverage indicates a deductible balance of $_____ and/or a co-payment of $_____.
Since you are responsible for paying for services that fall under your deductible/coinsurance/co-payment, please check the appropriate box to identify your selected payment method.

- o I will pay the deductible/coinsurance/co-payment for services I receive today in full prior to leaving the office today.
- o As a participating provider, my therapist will submit the claim on my behalf for services rendered directly to my insurance carrier. Upon receipt of my Explanation of Benefits from my insurance carrier, I understand that I am responsible for any applicable deductible/coinsurance/copayment **and I must provide payment directly to my provider within 30 days**. My provider and I have agreed to a financial arrangement/payment plan to pay for any applicable deductible/coinsurance/co-payment. If I do not pay in accordance within the agreed upon arrangement, I understand my provider may seek alternative methods to collect these monies.

I understand that I am responsible for paying my provider directly for any applicable deductible/coinsurance/copayment. This is a mandatory requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier, and seek alternative methods of collection. Failure to meet my obligations is a violation of my agreement with my insurance carrier and the carrier may take additional action. I also understand that if I have longstanding unpaid deductibles/coinsurance/co-payments owed to my provider, my provider may terminate the therapist/patient relationship as a result, subject to the requirements of state and/or federal law.

I further understand that if my provider collects any applicable deductible/coinsurance/copayment from me and is also reimbursed directly from my insurance carrier, that I will be reimbursed from my provider any overpayment owed to me, no later than 45 days after the provider's receipt of insurance carrier notification.

I agree to these terms:_____ Date_____

I have received my HIPPA privacy notice
Signature:_____Date_____

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Additional patient Information regarding office charges

Some services that therapists may provide are not covered by health insurance. The following is a list of **uncovered** charges:

Writing letters/Reports
Testing Materials
Phone calls lasting more than 10 minutes
Consultation with teachers/school
Attending meetings outside the office
Testifying in court
Consultation with attorney

These services are billed at an hourly rate of **$85.00** for master's level therapists and **$100** for psychologists, with the exception of testifying in court, which is billed at a flat rate of **$150.00** per hour for all therapists. **Your insurance can not be billed for the above services.** Only therapy sessions are covered by health insurance. If the service lasts only a fraction of an hour, then your charges are prorated to reflect the exact amount of time spent on the service.

If you have no insurance coverage or wish to pay cash for services the following is a list of charges, which reflects a **discount** for cash payments. Your payment is due at the time of the visit.

Master's Level Therapist		**Doctoral Level Psychologist**
90791 Initial Intake	$100.00	$110.00
90847 Family Therapy	$95.00	$105.00
90834 Individual Therapy	$85.00	$95.00

Signature_____

If you have any questions, please see the office manager.

Thank You.