HADDONFIELD PSYCHMANAGEMENT, P.A.
Comprehensive Psychological Services
www.haddonfieldpsychmanagement.com

31 Tanner Street
Haddonfield, New Jersey 08033
Telephone: (856) 428-7646
Fax: (856) 216-1839

PATIENT INFORMATION

Today's Date_____

NAME of the Doctor you will be seeing today_____

Patient's Name_____ Parent's/Guardian's Name (*if patient is a child*)_____

Patient Birth Date ___/___/___ Current Age_____ Gender: M F Marital Status_____ Patient's SS#_____

Patient's Address (*Street*)_____ *(Apt. #)* _____

(*City*)_____ (*State*) _____ (*Zip Code*) _____

Phone (*Home*)_____ Cell _____ Work # *for:* Patient – Parent - Guardian _____
(please circle)

Patient EMAIL address_____ ***(please print clearly)***

Emergency Contact & Number_____

List any major health problems_____

Medications you are currently taking _____

Have you ever received *Psychiatric* or *Psychological* services before? Y N If yes *(when & why)* _____

Referred to this office by_____

Primary Physician Name / Address_____ Phone_____

PLEASE READ CAREFULLY AND SIGN BELOW

- I authorize the payment of medical benefits for services provided at Haddonfield PsychManagement, P.A.
- I authorize the release of ANY and ALL treatment information as required by my insurer to process and review all related claims.
- "You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record…by signing this Agreement, you agree that I can provide requested information to your carrier."
- I acknowledge that I am responsible for payments for services that are not covered by my insurer to include deductibles, copayments, or any uncovered costs. To include insurance retraction of payment for valid reasons after services have been already rendered.
- I understand that copayments are due at the time of the delivery of service, unless prior arrangements have been agreed upon.
- I am aware that there are fees when requesting correspondence, reports and testing that are not covered by insurance carriers.
- I understand that if a patient is a minor, copayments are the responsibility of the parent or guardian who accompanies the minor.
- I acknowledge that the establishment of financial arrangements between separated, or divorced parents are not the responsibility of Haddonfield PsychManagement, P.A. And such arrangements should be clearly established prior to the provision of services.
- I understand my rights under the HIPPA Compliance Act and that a copy of the Protected Health Information Notice has been provided to me. At any time, I can request information or make inquiry at HPM to expand my understanding of my right to privacy.

(THE SIGNATURE OF THE PATIENT / PARENT / GUARDIAN INDICATES AGREEMENT AND ACCEPTANCE OF THESE CONDITIONS)

Patient_____ Date_____

Witness_____ Date_____

HADDONFIELD PSYCHMANAGEMENT, P.A.
Comprehensive Psychological Services

31 Tanner Street
Haddonfield, New Jersey 08033
Telephone: (856) 428-7646
Fax: (856) 216-1839

Cancellation Policy

Giving plenty of notice when cancelling an appointment is very important. It makes a substantial difference in our ability to serve. To avoid paying a fee for an ***exclusive*** and ***reserved*** appointment, cancellation must be timely. Kindly notify our office by noon, one business day before your appointment to avoid being charged. Weekends and holidays are not considered business days. Any questions regarding this policy are to be discussed with your doctor.

The charge for a ***late cancellation*** or ***failure to show*** for a scheduled appointment is $75.00.

A copy of this form will be given to the patient/parent for their records at the time of the initial office visit

(The signature of the patient/parent indicates agreement and acceptance of this policy)

Patient _____ Date _____

(Patient/Parent if patient is a minor)

Witness _____ Date _____

Revised 2/26/13

HADDONFIELD PSYCHMANAGEMENT, P.A.
Comprehensive Psychological Services
www.haddonfieldpsychmanagement.com

31 Tanner Street
Haddonfield, New Jersey 08033
Telephone: (856) 428-7646
Fax: (856) 216-1839

Financial Obligation

By signing this I am agreeing to assume full responsibility for any financial obligations incurred by the patient named below.

This will include copayment/deductible/co-insurance and missed appointment fees.

Payments are due at the time each office visit and can be given to the doctor if the office staff is not available. For your convenience you may also leave a credit card on file to be used with the office.

Name of Patient:
(print) _____

Name of Responsible Party:
(print) _____

(sign) _____ *(date)* _____

Relationship to Patient:
(print) _____