Laura DeMarco, Ph.D.
Clinical Psychologist
2 South Main St, Suite3
Andover, NY 14806
607-382-7008

NEW PATIENT INFORMATION

PATIENT INFORMATION

Patient Name:							
	Last		First		Middle Initial		
Address							
	Street Name and #		City		Zip Code		
Phone:	( )		Date of Birth:				
Leave Message?	Yes	No			Day	Month	Year
Email:			Gender:				
Marital Status:					Male	Female	Other
PCP Name:			PCP Phone:		( )		
Did he/she refer you?			Yes		No		
Do you wish me to have contact with this doctor?			Yes		No		
Emergency Contact:							
Relationship:			Emergency Phone:		( )		

INSURANCE INFORMATION

Who is responsible for copays, deductibles, non-covered services and other balances? (Please check only one.)				Patient		Other	
Patient's Relationship to Guarantor/Policy Holder:	Self		Spouse	Child		Other	
Policy Holder's Name (if other than self):							
	Last			First		M.I.	
Name of Insurance:				Policy Number:			
Phone Number on Back of Card:	( )						
Policy Holder's Date of Birth:							
				Month	Day	Year	
If your insurance requires you to have an authorization/referral, have you requested this from your PCP?				Yes		No	
Do you have a second insurance where claims should be submitted?				Yes		No	
If yes, what is name of insurance?				Policy #:			
Policy Holder's Name:							
Holder's Relationship to You:				Spouse		Other	
Phone Number on Back of Card:	( )						

In consideration of the provision of services to the above named patient rendered by Laura A DeMarco, Ph.D. I agree to be obligated to pay any remaining balance due not covered by my / patient's insurance carrier(s). I also agree to be obligated to pay any fees for missed appointments and canceled appointments with less than 24 hour notice, as these types of charges are not billable to my insurance carrier. In addition, I authorize Laura A DeMarco, Ph.D. to release to parties responsible for payment of my / patient's mental health service bill(s) such information as may be necessary for the completion of financial obligation; this includes sharing information with Dr. DeMarco's billing office. All such transactions will be undertaken under conditions of confidentiality.

Patient Signature	**Date**

Patient Name:		**D.O.B.:**	

Presenting Problem: What is the main concern that prompted you to make this appointment?

Psychiatric and Psychological History: Provide all past mental health and substance abuse treatment, including outpatient and inpatient.

Medication History:
List all current psychiatric medications:

DRUG	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

Past Medications:

List current medications other than psychiatric:

DRUG	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

List any **non-**prescription medications:

Medical and Surgical History—Past/Present

Patient Name:		D.O.B.:	

Social History (If child, marital status of parents):											
Status:	Single		Married		Widowed		Divorced		Separated		Partnered	
Name:												

Children (if a child, please list sibling):			
Name:	Age	Location	Custody (Joint/Single, etc.)

Pertaining to children who will be seen:			
Lawyer:		Phone:	
Law Guardian:		Phone:	
School Counselor:		Phone:	

Financial Policy

I am dedicated to providing the best possible care for you, and I want you to completely understand my payment policies.

1. Insurance: I participate in most insurance plans, including Medicare. If you are insured by a plan I do business with but do not have an up-to-date insurance card, payment in full for each visit is required until I can verify your coverage.

2. Co-payments and Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. For your convenience I accept MasterCard and Visa. **You will be billed a $10 handling fee for not paying your co-pay at the time of service unless other arraignments have been made.**

3. Non-covered Services: Be aware that some and perhaps all of your services you receive may be non-covered or not reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

4. Proof of Insurance: All patients must complete out patient registration form before being seen. I must obtain a copy of your current valid insurance card to provide proof of insurance. **If you fail to provide us with the correct insurance information in time to meet your insurance company claim filing limit, you will be responsible for the balance of the claim.**

5. Claims Submission: I will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; I am not party to that contract.

6. Coverage Changes: If your insurance changes, please notify me so I can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Non-payment: If your account is over 30 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payment will not be accepted unless otherwise negotiated. Please let me know if you are encountering financial problems and a sliding scale fee can be arranged. Please be aware that if a balance remains unpaid, I may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternate care.

8. NO SHOW Fees: **The number of patients requiring services dictates the use of time responsibly.** Please be advised of the institution of a no show fee for failure to come to a scheduled appointment without at least 24 hours prior notice with the exception of an emergency. This fee cannot be billed to an insurance company and is due prior to your next appointment. We reserve the right to not reschedule future appointments.
   No Show Fee $70.00 **Late Cancellation** $40.00

Patient Name:		D.O.B.:	

Professional Fees

The fee for the initial diagnostic consultation and clinical interview is $200.00. My regular hourly fees for a 50 –minute to 60-minute individual psychotherapy session is $125.00, 20-minute to 30-minute is $110.00. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will breakdown the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations, consulting with other professionals on your behalf, preparation of records or treatment summaries, and the time spent performing any other service required of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time including preparation and transportation cost even if I am called to testify by another party. I charge $215.00, accrued in 15 minute intervals for preparation and attendance at any legal proceeding.

I have read and understand the Financial Policy and Professional Fees and agree to abide by these guidelines:

Signature of patient (or responsible party, if minor)	**Date**

Informed Consent for Treatment

Clinical records are kept under the strictest rules of confidentiality, which means that information about your treatment will not be releases to any outside agency or individual without your written permission. Please be advised, however, that rules of confidentiality will be broken under certain circumstances as described in the **NOTICE OF PRIVACY PRACTICES** below. Please do not hesitate to ask questions.

Entering mental health treatment is a courageous step. You should know that sometimes symptoms become worse before they become better, though this should subside as the work of treatment progresses. You may be asked to participate in activities and tasks outside the sessions held here. While you have the right to refuse any therapeutic technique, we must be able to discuss your thoughts and feelings about treatment. You will be involved in the process of designating and implementing, and the periodic review, of your treatment plan. You have the right to be informed of your mental health diagnosis after an initial assessment is completed. You also have the right to withdraw consent and terminate services at any time.

I authorize Laura DeMarco, Ph.D. Psychologist to treat me per the psychological services discussed.

Signature of patient (or responsible party, if minor)	**Date**

HIPAA

I have reviewed the HIPAA privacy statement.

Signature of patient (or responsible party, if minor)	**Date**