

**LILLEY & ASSOCIATES
STONEBURNER & ASSOCIATES, LLC**

A Practice of Independent Mental Health Professionals

CLIENT INFORMATION SHEET FOR PSYCHIATRIC SERVICES

For Staff Use: Assigned Psychiatrist: JBOV HSCH ASHA Case #: _____ Case opened by initials: _____	Checklist: HIPAA _____ All Intake Date Completed ____ All Signatures Obtained ____
---	--

Initial Information Today's Date: _____

Client Name: _____		
_____	_____	_____
First	Middle	Last
Street Address: _____		
City: _____ State: _____ Zip: _____		
Home Phone: _____ Work Phone: _____ Pager: _____		
Cellular: _____ Fax: _____		
Email: _____		
Birthdate: _____ Sex: _____ Social Security #: _____		
Marital Status: _____ Spouse's Name: _____		
Parent(s)/Guardian(s) if patient is a minor: _____		
<u>Responsible Party Information:</u> If the client is not financially responsible for payment of services, please complete the following information concerning the responsible Party.		
Responsible Party First Name: _____ Last Name: _____		
Street Address: _____ City: _____ State: _____		
Zip: _____		
Social Security Number: _____ Birthdate: _____		
Relationship to Client: Parent(s) ____ Guardian ____ Spouse ____		
Home Phone: _____ Work Phone: _____ Cellular: _____		

Fee Policy for Psychiatric Services

The professional staff of sole proprietors at Stoneburner and Associates, LLC and/or Lilley & Associates (hereinafter referred to collectively as 'management') are committed to providing caring and professional mental health care to all of our clients/patients. As part of the delivery of mental health services, a financial policy has been established and clarified to state clearly the obligations of management and of clients/patients.

The person designated by the patient/parent/guardian as the Person Responsible for Payment of Accounts is required to sign the Fee Policy that explains the fees and collection policies of the management company relative to the psychiatric practice.

**Without exception, the Person Responsible for Payment will be financially responsible for payment of fees in full to the psychiatrist
AT THE TIME OF SERVICE.**

Should the Party Responsible for payment fail to pay fees at the time of service, a 5% per month interest rate will be assessed beginning in the month when the services are rendered and for every month thereafter on the amount owing until the amount is paid in full and the account will be forwarded for collections processing.

While payment is due at the time of service, the patient/parent/guardian may choose to submit a claim for reimbursement to the company that insures the patient/client. A receipt will be provided to the patient/parent/guardian at the time of service and payment with all the information required for insurance reimbursement should the insured's policy provide for such reimbursement. The patient/parent/guardian is responsible for any requirement prior to sessions with the psychiatrist for obtaining pre-certification or pre-authorization if required by their health insurance carrier to receive reimbursement. Neither the psychiatrist nor management shall in any way be responsible for submittal of such insurance claims nor for the third-party reimbursement beyond providing appropriate verification of the service and payment to the patient/parent/guardian for their use in obtaining insurance reimbursement.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at rate equal to the full rate for services that were scheduled with the psychiatrist. Payment of such fees for missed appointments or cancellations will be due in full 10 days from the date of the appointment missed or late cancellation.

There is normally no charge for telephone consultations with clients and with other professionals if such phone contacts are 15 minutes or less in duration. Telephone calls exceeding 15 minutes, will be prorated at the psychiatrist's standard hourly rate.

Payments will be accepted from the Person Responsible for Payment by check, cash or charge cards, including VISA and MASTERCARD. Clients using charge cards may utilize the cards as charge cards or debit cards.

The psychiatrist can answer any questions regarding the financial policies as stated above.

I have read, understand and agree with the provisions of the above-stated Fee Policy:

Treatment

For adults receiving services:

I hereby give my consent to receive treatment and related services from the designated professional(s) providing services to me at Stoneburner & Associates, LLC, and Lilley & Associates. I understand that this consent is for the duration of the services to be provided.

Client Name (please print)

Client Signature

Date

Witness Signature

Date

If patient is a minor, the parent or guardian should sign this statement:

I hereby give my consent as parent or guardian for the following individual to receive treatment and related services from the designated professional(s) providing services at Stoneburner & Associates, LLC, and Lilley & Associates. I understand that this consent is for the duration of the services to be provided.

**LILLEY & ASSOCIATES
STONEBURNER & ASSOCIATES, LLC**

Consent for

Client Name (please print)

Parent or Guardian Name (please print)

Parent or Guardian Signature

Date

Witness Signature

Date