Children's Psychological Services
www.childrenspsychologicalservices.com
Tel: 415-484-8479

Financial Responsibility Form

Patient First Name: ______________________________ Last Name: ____

Patient Date of Birth: _________________________________ Adopted or Foster child (X): Yes?______ No?_______

Parents Relationship Status: ____________Legal/Physical Custody (X) Joint? ___ Mother? ___ Father? __ Guardian? __

Parent/Guardian Name #1:____

Address: ____City:______________ State:______ Zip:_________

Cell #: ____________________________ Home Phone #:_________________Office #:_________________________

Parent #1 DOB: ___________________________ Email Address: ____

Employer Name:____________________________________ Occupation _____________________________________

Parent/Guardian Name #2: ____

Same Address? (X) Yes? ___No?:___Parent #2 Address: ____________________City:______ State: ____ Zip: _______

Cell #: ____________________________ Home Phone #:_________________Office #:_________________________

Parent #2 DOB: ___________________________ Email Address: ____

Employer Name:____________________________________ Occupation _____________________________________

INSURANCE INFORMATION
(ATTACH COPY OF INSURANCE CARD FRONT AND BACK)

Primary Insurance: _____________________________________ ID#:____

Insured Name: _____________________________________ Relation to patient: _________________________________

Group #:_________________ Effective Date: ________________________ Insurance Phone #: ______________________

Secondary Insurance: __________________________________ ID#: ____

Insurance Address:___________________________________ City/State/Zip:_______________________________________

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PATIENT FINANCIAL AGREEMENT

CONFIDENTIALITY:
I understand that my records are confidential and will not be released to outside individuals of agencies without written consent. However certain information may be released without my authorization under the following circumstances:

1. In the event of a medical emergency.
2. Suspicion of child abuse, dependent or elder abuse.
3. When a hazard to the public requires disclosure
4. When there is an indication that I will likely harm myself.
5. Collection Agency
6. Medical Insurance Company (if applicable)

COPAY:
I understand that I am financially responsible for any affiliated with each parent and patient session. I agree to pay the copay. I understand that my insurance carrier does not cover this cost.

RATES:
Hourly Rate: $200.00
Autism (ASD) Evaluation Only (Three tests): $1500.00
Developmental Assessment for Children under five: $1500.00
Comprehensive Assessment for Adolescents and Adults (over age five): $3000.00

EXPLANATION OF BENEFITS:
I understand and agree that I am fully responsible for any cost that is not covered by my health plan. I agree to pay the hourly rate or flat rate, as noted above, as discussed by Dr. Trish Singh PsyD.

CANCELLATIONS:
Appointments are regarded as contract for the exclusive use of the doctor's time. I understand that regular charges of $200.00 an hour may be applied to missed appointments without 24 hours advance cancellation notice. I understand that my insurance carrier will not pay for my absence and I will be responsible for these charges.

I, the undersigned, certify that I (or my dependent) have insurance coverage with________________________ insurance company (ies) and assign directly to Trishanjit K. Singh, PsyD/Children's Psychological Services, all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether paid by the insurance or not. I understand that outstanding balances will be forwarded to a collection agency. I understand that, if court proceedings occur, I am responsible for all litigation fees, including lawyer fees, for Children's Psychological Services. I hereby authorize the doctor/clinician to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all insurance submissions.

______________________________	______________________________	________________
Signature of Responsible Party/Parent #1	Printed Name	Date
______________________________	______________________________	________________
Signature of Responsible Party/Parent #2	Printed Name	Date