



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:

Autism (ASD) Evaluation Only (Three tests): \$1500.00 flat rate
Developmental Assessment for Children under five: \$1500.00 flat rate
Comprehensive Assessment for Adolescents and Adults (over age five): \$3000.00 flat rate

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