RACHEL LACY, PSY.D., P.C.

NEW PATIENT INFORMATION SHEET

Name:_____ Date:_____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Street address (no P.O.) if different from mailing: _____
_____
Home Phone: _____Work Phone: _____
Mobile: _____Other: _____
Date of Birth: _____Age: _____ Gender:_____
Social Security Number: _____
Marital Status: __Single __Married __Separated __Divorced __Widowed
Occupation: _____ Employer: _____
Referred by: _____ Phone: _____
Personal Physician: _____
What services are you seeking? _____
Are you currently involved in litigation? _____
Attorney's Name: _____
If injured, was injury due to auto accident? _____ Date of accident: _____
Is this a workers' compensation claim? _____ Date of Injury: _____
Date last worked: _____
Do you have a legal guardian? _____ Name of guardian: _____
Phone number: _____ Relationship to Patient: _____
Is he/ she a guardian of person, property, or both? _____

PRIMARY INSURANCE:

Insurance Carrier: _____
Insured's Name: _____ Relationship to Patient: _____
Insured's Date of Birth: _____Insured's Social Security Number: _____
Member ID number: _____ Policy Number: _____Group Number: ____

SECONDARY INSURANCE:

Insurance Carrier: _____
Insured's Name: _____ Relationship to Patient: _____
Insured's Date of Birth: _____Insured's Social Security Number: _____
Home Phone: _____ Work Phone: _____
Member ID number: _____ Policy Number: _____Group Number: ____

AUTHORIZATION OF RELEASE AND ASSIGNMENT OF BENEFITS:

I hereby authorize Rachel Lacy, Psy.D., P.C. to provide information requested by insurance companies with whom I have the coverage in order to process insurance benefits. I hereby authorize payment of benefits directly to Rachel Lacy, Psy.D. I understand that I am responsible to Dr. Lacy for the charges not covered by this agreement.

_____ _____ _____

Responsible Party Signature **Relationship to Patient** **Date**

Billing Agreement

Your signature below acknowledges that you accept responsibility for payment of services rendered by Rachel Lacy, Psy.D. Payment for all visits is due at the time that services are provided unless other arrangements are made prior to treatment.

If Dr. Lacy is on your insurance panel, you will be responsible for any co-pay or deductible and we will submit your claim for the balance due. Dr. Lacy is a Medicare provider and will file Medicare claims for you. You will only be responsible for the portion that Medicare assigns to you as your responsibility.

If Dr. Lacy is not on your insurance panel (out-of-network provider), you may still be entitled to benefits from your insurance company, but Dr. Lacy's full fees are ultimately your responsibility regardless of the insurance reimbursement. You acknowledge that you are responsible for all fees not covered by your insurance. We will provide necessary documentation for you to file your insurance claim unless other arrangements are agreed upon prior to treatment. In most cases, you will need to pay for services at the time of your session and you will be reimbursed by your insurance company. Master Card and Visa are available for your convenience and debit cards are also accepted.

If you have not made a payment on your account for more than 60 days, including payments agreed upon as part of a payment plan, we will submit the charge for your full balance to your credit card using the credit card information you provide on this form. Payment plans for testing are available; however, as part of your agreement, steady payments must be made each month to keep the account up to date. We also reserve the right to send delinquent accounts to collections or pursue legal action if necessary if you fail to pay the balance of your account.

I have read and agree to the billing policy outlined above and accept responsibility for payment of services rendered by Rachel Lacy, Psy.D. For payment of this account, I waive all claims of exemption under the State of Georgia and agree to pay if necessary all costs of collection. I understand that my appointment time is reserved for me and that the office of Dr. Lacy requires 24 hour notice of cancellation or a fee will be charged for the time reserved. I also understand insurance does not reimburse for missed appointments and I will be responsible for the full fee.

_____ _____

Patient/ Guardian Signature **Date**

Credit Card Number;_____(Mastercard or Visa)

Expiration Date: _____ **Billing Zip Code: _____**

Name on Card: _____

Authorized Signature matching name on card: _____