Nonie Griscom Therapy LLC
130 Bellevue Ave. Suite 214
Newport, RI 02840
561-301-5657

Date______________

PATIENT INFORMATION

Name____
(last) (first) (Middle)

Sex___M____F Age_________ Birthdate _____________ Home phone________________
Home Address____
Email address:____
Person Financially Responsible____________________________Cell phone________________
Work phone_________________
Whom may we thank for referring you? ____

INSURANCE COVERAGE

Insured's name____
Address (if different from patient's)____
Home phone (if different) _________________________ work phone________________________
Employer____
Social Security Number___________________Birthdate_____________________
Insurance Plan Name________________________ phone number__________________________
Insurance Plan Address____
Group#___________________________Policy #________________________________
Emergency contact person, address ____
phone ___________________________________

RELEASE AND ASSIGNMENT

This information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my insurance status. I certify that is covered by insurance with and assign directly to Nonie Griscom Therapy all insurance benefits for services provided. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signed_____________________________________Date______________________________

I allow/not allow Nonie Griscom Therapy LLC to contact
my primary care physician:____

Signed____Date________________

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Dear New Client,

Welcome to my practice! Please carefully read the following information and sign below. It is important that the financial issues be clarified before we work together, so you do not have to be concerned with these at a later date.

Payment Information
Individual and family therapy are provided at a rate of $200.00 per 45 minute interval, unless you are using insurance coverage with which I have a contract. In that case, a discounted amount will be charged to your insurance and your copayment will be accepted at the time of the visit. For all other insurance, the amount must be paid in full until reimbursement rates are established and all deductibles have been met. If you are unsure what portion of these charges your insurance policy will cover, please contact your insurance company or consult the literature provided by your employer or insurance company. Please check your coverage as soon as possible to avoid being surprised by receiving less reimbursement than you expected. Any balance not paid by your insurance company is your responsibility.

Please have your payment ready at the start of the appointment, which allows us to focus on treatment, not payments. Checks should be made out to Nonie Griscom Therapy LLC. Cash and credit cards are also accepted.

Canceling Appointments
Please make note of all your appointments. Appointments not canceled at least 24 hours prior to the scheduled visit will be billed to you at a cost of $75.00. Please be aware that your insurance will not pay for missed appointments. This is necessary to keep our business running. As you may be aware, we have set aside a considerable amount of time just for you, and when an appointment is cancelled without notice we are unable to give that time to anyone else who may need it. With prior warning, we are often able to fill the vacant time with another client who wishes to be seen.

Emergencies
This office is not readily equipped for emergency services. However, in the event of an emergency, you may try to reach us by pager or cellular phone, and we make every attempt to be available to our clients. However, in the unlikely event that my colleagues or I cannot be reached, please go to the nearest emergency room. If we are out of the area or on vacation, another provider will be arranged to accept all emergency calls.

Authorization to bill insurance
I authorize the release of any medical information necessary to process this claim and request the payment of any commercial insurance carrier benefits either to myself or to the provider or service. My signature below indicates that I have read and understood the above policies.

I agree to these terms:____Date:______________

Collection of Deductible/Coinsurance/Copayment Contract

Client's Name: ______________________________________Client's DOB ____ / _____/_______

Client's Health Plan:____

Client's ID Number:____

Client's Mailing Address:____

City: _______________________State:__________ Zip Code:_______________

Dear Client,

We have verified with your insurance carrier that your insurance coverage indicates a deductible balance of $________ and/or a co-payment of $ _________.
Since you are responsible for paying for services that fall under your deductible/coinsurance/co-payment, please check the appropriate box to identify your selected payment method.

o I will pay the deductible/coinsurance/co-payment for services I receive today in full prior to leaving the office today.
o As a participating provider, my therapist will submit the claim on my behalf for services rendered directly to my insurance carrier. Upon receipt of my Explanation of Benefits from my insurance carrier, I understand that I am responsible for any applicable deductible/coinsurance/copayment and I must provide payment directly to my provider within 30 days. My provider and I have agreed to a financial arrangement/payment plan to pay for any applicable deductible/coinsurance/co-payment. If I do not pay in accordance within the agreed upon arrangement, I understand my provider may seek alternative methods to collect these monies.

I understand that I am responsible for paying my provider directly for any applicable deductible/coinsurance/copayment. This is a mandatory requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier, and seek alternative methods of collection. Failure to meet my obligations is a violation of my agreement with my insurance carrier and the carrier may take additional action. I also understand that if I have longstanding unpaid deductibles /coinsurance/co-payments owed to my provider, my provider may terminate the therapist/ patient relationship as a result, subject to the requirements of state and/or federal law.

I further understand that if my provider collects any applicable deductible/coinsurance /copayment from me and is also reimbursed directly from my insurance carrier, that I will be reimbursed from my provider any overpayment owed to me, no later than 45 days after the provider's receipt of insurance carrier notification.

I agree to these terms:_________________________________Date______________

I have received my HIPPA privacy notice

Signature:____ Date______________

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Your payment is due at the time of the visit for a 45-minute session:

90791 Initial Intake	$250.00	
90847 Family Therapy	$200.00 (45 min)	$250 (60 min)
90834 Individual Therapy	$200.00 (45 min)	$250 (60 min)

Signature______________________________________

If you have any questions, please see the office manager.

Thank You.