COGNITIVE THERAPY & CONSULTATION, LLC

597 Springfield Ave.
Summit, NJ 07901

New Patient Information *(Please print clearly)*

Patient's Name: ______________________________ ______________________

Parent's Name, if patient is a child: _____________________________________

Birthdate: ____ ___ ______ E-Mail: ________________________@______________

(*May we send appointment and non-clinical information to this e-mail?)*

Phones: Home (____) ___- __________ Cell (_____) _____- _________

Work (____) ____ -_________________________(*On which phone may we leave a message?)*_________

Address: _______________________ City: __________________ State: ___ Zip _______

Last four digits of Social Security Number ______ Marital Status: ___

Referring Physician or/Person: _______________________ Phone: (___) ________________

City: ________________ State: _____ Zip: ___________

Person to Notify in Case of Emergency: Name _________________________

Relationship: ______________ Phone: ( ) _____ -__________

Address: _________________ City: ____________ State: ___ Zip: __

Your employment status:

Full time __ Part time__ Not Employed __ Retired __ Student __ Full time homemaker/mother ___

Occupation: _________________________ Highest grade of school completed: ______

Employer Name: ___________________ Address: _____________________________

Responsible billing party (or parent name if patient is a minor) & address if different:

Name: __________________________ Relationship: ____________

Address: __________________________ State: ___ Zip: _____

Phone: _______________________

Please See Page 2.

Financial Arrangements and Medical Insurance if Applicable

Psychotherapeutic treatment is a joint responsibility between the patient and the therapist. I am committed to providing you with the best possible care.

We require that payment for services be made at the time the service is rendered. I accept both cash and checks. Any account balance past 30 days will be subject to a finance charge of 1% per month or 12% per year. All returned checks will be subject to my bank's processing fee.

Scheduled or standing appointments are billable unless telephone cancellation notice is received 24 hours in advance of your scheduled appointment. Appointments canceled with less than 24 hours advance notice will be charged for the full missed session.

Insurance and managed care companies will not reimburse you for missed sessions and the patient must bear the responsibility for the cost of a session ***canceled with less than 24 hours notice.***

I realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact me promptly for assistance in the management of your account.

You must be aware that your insurance is a contract between you, your employer and the insurance company. I am not a party to the contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Please understand that my relationship is with you and not your insurance company.

All charges are your responsibility from the date the services are rendered. You are financially responsible for the balance. Please contact your insurance company for an explanation of your benefits, deductibles and copayments on your coverage and how they will reimburse you for "out of network" providers.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

- I AUTHORIZE THE RELEASE OF INFORMATION TO MY INSURANCE COMPANY.
- I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.
- I AUTHORIZE *Cognitive Therapy & Consultation* (CTC), LLC OR ITS AGENTS TO ACT ON MY BEHALF TO HELP ME SECURE PAYMENT FROM MY INSURANCE COMPANY.

_________________________ _____________________

SIGNATURE DATE

Notice: **PLEASE SIGN THE FORM AFTER READING IT AND BRING THE SIGNED FORM TO YOUR FIRST VISIT.**

If you have any questions concerning the above information, please do not hesitate to ask me.
I am here to help you. Do not sign this agreement before you read and agree to the conditions set forth above.

Please complete the registration information on the other side of this page.