COGNITIVE THERAPY & CONSULTATION, LLC
597 Springfield Ave.
Summit, NJ 07901
(908) 273-3133

Date:_____

New Patient Information ***(Please Print Clearly)***

Patient's Name: _____ _____

Birth date: __ ___ ____ E-Mail: _____@_____

May we send E-mail* appointment messages? Y __ N __ *May we send text messages to your cell phone?* Y __ N__

Phones: Home (____) _____- _____ **Cell (**_____) _____- _____

Work (____) _____ -_____ _____(*On which phone may we leave a voice message*) _____

Home Address: _____City:_____ State: ___ Zip _____

Last four digits of Social Security Number: _____ Marital Status: _____

Referring Physician or Source of Referral _____

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 parent ___

Occupation: _____ highest grade of school completed _____

Employer Name: _____ Address: _____

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

Name: _____ Relationship: _____

Phone: _____Address: _____

City:_____ State: ____ Zip:_____

SEE REVERSE SIDE AND SIGN ON THE BACK AFTER READING

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.

I require that payment for services be made at the time the service is rendered unless other arrangements have been approved in advance. I accept both cash and checks.

Scheduled or standing appointments are billable unless cancellation notice is received 24 hours in advance of your scheduled appointment. * Monday appointments require a cancellation on Friday before 5:00 P.M. to avoid a session fee. Appointments canceled with less than 24 hours or (*Friday advance) notice will be charged the full session fee.

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 ***cancelled 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.

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.

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

I authorize CTC, LLC to send E-mail and text messages regarding appointment scheduling.
***Please Note: Please be aware that E-mail is not secure and no personal information should be sent electronically.**

_____ _____

SIGNATURE DATE