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

New Patient Information ***(Please print clearly)*** **Date:**_____

Patient's Name: _____ _____

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

May we send E-mail* appointment reminders? Y __ N __

Phones**:** (Please check ✓ preferred phone)

__ Cell: (_____) _____- _____

May we send text messages to your cell phone? Y___ N___ Leave voice messages? **Y** ___ N ___ *Both voice and text ? Y ___N ___*

__ Home: (_____) _____- _____ *May we leave voice messages?* **Y** ___ N__

___ Work : (_____) _____-_____ *May we leave voice messages?* **Y** ___ N__

Address: _____ City:_____ State: ___ Zip: _____

Marital Status:_____

Referring Physician or/Person**:** _____ Phone: (___)_____

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: _____

Person to Notify in Case of Emergency: Name:_____

Relationship: _____ Phone: ( ) ____ -_____

Address: _____ City: _____ State: ___ Zip:_____

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

Name: _____ Relationship: _____

Phone: _____

Address: _____ (if different than patient) 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 cancellation by Friday at 5:00 P.M to avoid charges. Appointments canceled with less than 24 hours advance notice (*or Friday for Monday) 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.

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.

Dr. Schonberg is a "non-participant" in the Medicare program. If you wish to begin treatment with her and you are insured by Medicare or are Medicare eligible, you must sign a private agreement indicating both your willingness to pay her usual private rate and your understanding that the bill can't be submitted to Medicare for reimbursement.

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