Today's Date: _____

Chambers & Blohm Psychological Services
309 North Mandan Street – Suite #1
Bismarck, ND 58501
(701) 323-0924

Client's Name: _____ MALE FEMALE OTHER ☐
First MI Last

Date of Birth: _____/_____/_____

Address: _____
Street Address City State Zip Code

Social Security # _____ Responsible Party _____

Address: _____

Home Telephone Number: _____ Cell Phone Number: _____

Email Address: _____

Client's Employer / School: _____ Employer's Telephone Number: _____

Spouse's Name: _____ Employer _____ Employer's Telephone Number: _____

If Child: Father's Name: _____ Employer _____ Employer's Telephone Number: _____

Mother's Name: _____ Employer _____ Employer's Telephone Number: _____

Primary Care Physician: _____

Emergency Contact:

Name _____ Relationship _____

Address _____ Telephone _____

INSURANCE: ***Please check the appropriate insurance and complete its designated section.***

***** Please note: You, the client is responsible for knowing and understanding your insurance coverage/benefits. It is the client's responsibility to call their insurance company to verify services before services are rendered..***

Medicare: Medicare Number: _____

BCBS Policyholder _____ Date of Birth: _____
(Name on Card) (of PolicyHolder)

Policy Number _____

Other Insurance: Company Name and Address _____

Policy Holder _____
Name and Date of Birth

Policy Number _____ Group Number _____

Medicaid: Medicaid Number: _____ County: _____

Self Pay ***(please note: It is required that self-pay clients must pay for services <u>prior</u> to the services being rendered)***

I hereby authorize Chambers & Blohm Psychological Services to furnish information to insurance carriers concerning any services rendered to me or any member of my family, and I hereby assign to Chambers & Blohm Psychological Services all payments for services rendered. I understand that I am financially responsible for all charges.

***** Please note: You, the client, are responsible for knowing and understanding your insurance coverage/benefits. It is the client's responsibility to call their insurance company to verify benefits before services are rendered.***

Signed: _____ Date: _____

Chambers & Blohm Psychological Services

STATEMENT OF FINANCIAL UNDERSTANDING

BILLING POLICIES

As a service to our clients, Chambers & Blohm Psychological Services is capable and willing to assist you with filing of insurance claims and answering any billing questions. All information requested is necessary for the proper processing of claims, and to speed up the billing process. Without this information, the bill will be sent directly to you.

Chambers & Blohm Psychological Services will not accept the responsibility for collection of insurance claims or negotiate settlements in disputed claims. Please recognize that you, the client is responsible for the bill. If problems arise in the processing of these claims we will provide any assistance possible.

MEDICARE BENEFITS

Chambers & Blohm Psychological Services is a participant in the Medicare Program and does accept Medicare assignment. We will be happy to submit any balance following payment from Medicare to your supplemental insurance providing complete information is furnished.

WORKERS COMPENSATION

North Dakota Workers Compensation claims are submitted directly to the Workers compensation Bureau by Chambers & Blohm Psychological Services. If the Workers Compensation is through another state, the claim will be completed by our office and sent directly to you for submission to your individual Workers Compensation Insurance Fund.

NO FAULT

If your visit to the clinic is due to a motor vehicle accident, you will be asked for the name and address of the insurance company along with the claim number and date of accident. If you cannot provide this information, we will consider the balance your responsibility.

PAYMENT PROCEDURES

Benefits paid directly to Chambers & Blohm Psychological Services are credited to your account and will be notified on the statement of any balance due.

When benefits are payable directly to, you are responsible for submitting that payment to the clinic. At that time your account will be credited and you will be notified on the next statement of any balance due.

We understand there are clients who have financial difficulties and encourage them to discuss their situation with us so payment arrangement can be made.

Chambers & Blohm Psychological Services will not extend credit to a client who fails to make payments, unless you consult with our office. These accounts may be turned over to an outside agency for collections. Payment arrangement can be made by calling (701) 323-0924.

CONFIDENTIALITY

The staff of Chambers & Blohm Psychological Services does everything possible to assure your confidentiality. Your limits to Confidentiality may be limited by law or regulations in some situations, such as;

1. the person who is a harm to him/herself or others;
2. disclosure of suspicion of child abuse or neglect previously unreported;
3. a court ordered request for records, or
4. access by the support staff directly providing your care or completing quality assurance activities

Other considerations:

1. in the case of a minor or child, we reserve the right to communicate with client or guardian;
2. older children, especially teens, will be allowed the same privacy as an adult; parents/guardians will be offered suggestions in enhancing their care.

Chambers & Blohm Psychological Services

OFFICE PROCEDURES AND BILLING POLICIES

Chambers & Blohm will submit claims to the client's insurance provider. In order to do so, a copy of the client's insurance card will be made. It is the client's responsibility to notify the office of any change in address, phone number, or insurance carrier. If a client does not have insurance**,** payment is required prior to receiving services.

If a client has a co-payment, the co-pay is due the day services are rendered.

Our office will bill the client the balance after the insurance payment is received. Payments are expected 15 – 30 days after the statement has been mailed. Sessions will be suspended and no additional appointments will be scheduled until account balance is paid in full, or other arrangements have been made.

PLEASE NOTE: COLLECTION PROCEDURES: Clients will be sent monthly statements. They will be notified if the balance is past due. After 60 days with no payments or effort to arrange payment, services will be terminated. Overdue accounts will be turned over to a collection agency. If an account is turned over to collections and the client requests to return for services, exceptions may be made; however, the commission fees paid to the collection agency will be billed back to the client's account.

NO SHOW POLICY: Clients are expected to cancel or reschedule all appointments 24 hours in advance. Clients will be responsible for a $50 fee if they do not notify the office of a cancellation or re-scheduled session AT LEAST 24 HOURS IN ADVANCE. This is because a time commitment is made and held exclusively for them. Cancellations and re-scheduled sessions will be assessed on a case-by-case basis. If the client is late for a session, they will lose that session time. Clients who arrive 15 or more minutes late for an hour-long appointment will be required to reschedule their appointment. Services will be terminated if a client fails or late cancels three consecutive appointments (or sooner per the provider's clinical discretion.)

MINOR CHILDREN: The office and employees of Chambers & Blohm **are not** responsible for minor children left in the waiting room area unattended.

VALUABLES: The client is responsible for the retention of personal articles. Chambers & Blohm will not assume responsibility for the loss or any damage of client's personal articles (e.g. money, jewelry, eyeglasses, dentures, hearing aids, cell phones or other electronic devices, or clothing, etc.).

****** Please see back of page for additional information and required signature.***

LEGAL INVOLVEMENT: The minimum fee for a trial, hearing, deposition or similar proceeding is $1,200, based on an anticipated four hour minimum for preparation and time for testimony. The clinician is usually required to take at least a half day off work and is unable to see clients while preparing or waiting to testify. This amount must be paid at least one week prior to the clinician's scheduled testimony.

TERMINATION OF SERVICES

(a) Providers may terminate services when it becomes reasonably clear that the client no longer needs or is benefiting from treatment.

(b) Provider will terminate therapy when threatened or otherwise endangered by the client or other person with whom the client has a relationship.

(c) Services will be terminated for failure to comply with office and billing policies.

(d) Services will be terminated if the client's outstanding balance has been turned over to collections.

(e) Services will be terminated if a client has filed bankruptcy and there is an outstanding account balance.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

Chambers & Blohm Psychological Services is authorized to release confidential mental health, behavioral health, chemical dependency, and protected health information to third party payers, insurers, Social Security Administrators, and Medicare.

The client or other legally obligated individual is financially responsible for services rendered.

I assign and authorize any third party payer/insurer to make direct payment to Chambers & Blohm Psychological Services. I authorize the refund of overpaid insurance benefits to the insurance company.

I acknowledge that I have read the front and back of the office procedures and billing policies of Chambers & Blohm Psychological Services and have agreed to their terms.

Client Signature (or Guardian) **Print Name**

Date

Chambers & Blohm Psychological Services

AUTHORIZATIONS AND RELEASES

Client Name: _____ Client Number: _____

1. AUTHORIZATION FOR EVALUATION/TREATMENT

I hereby authorize the professional in charge of the above named client to evaluate and administer treatment necessary or advisable.

2. LIMITS OF CONFIDENTIALITY

I understand the limits of confidentiality as outlined on the reverse side of this form.

3. RELEASE OF INFORMATION FOR INSURANCE CLAIMS

Chambers & Blohm Psychological Services is authorized to release all or part of the client's medical record to any person or corporation which is or may be liable for any part of the clinics charges, including but not limited to, hospital or medical service companies, insurers, compensation carriers, or government agencies. It is understood that photo copy of this form is a valid authorization for release.

4. ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of any insurance benefits arising from policies insuring the client or any party liable to the client, directly to Chambers & Blohm Psychological Services. I understand that I am financially responsible for any charges not covered by this assignment.

5. FINANCIAL RESPONSIBILITY

In consideration of the services to be rendered to the client by the provider, the undersigned guarantees that payment of any amount due. I have read the Statement of Financial Understanding on the back of this form and I assume financial responsibility for the expenses of the above named client.

6. MEDICARE SIGNATURE ON FILE

I hereby authorize payment of Medicare Benefits be made either by me on my behalf to Chambers & Blohm Psychological Services. for any service furnished me by the listed provider. In Medicare assigned cases, the provider agrees to accept the charge determination of the medicare carrier as the full charge, and the client is responsible only for the deductible, coinsurance and noncovered services.

7. VALUABLES

The client is responsible for retention of personal articles, Chambers & Blohm Psychological Services will not assume responsibility for the loss of client's personal articles. (e.g., money, jewelry, eyeglasses, dentures, hearing aids, clothing, and fur garments, etc.)

8. CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, have received a copy of the foregoing and being the client, guarantor, or being duly authorized by the client, do agree and accept its terms.

_____ _____

Client or authorized signature Relationship to Client

_____ _____

Signature of Witness Date

*Please **READ** each item, **INITIAL** each item and then **SIGN** and **DATE** on the bottom of this form.*

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a written copy of the Chambers & Blohm Psychological Services Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be part of my record until such time as I may choose to revoke this acknowledgment. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____ _____

Date Signature of Patient or Authorized Agent

_____ _____

Patient's Date of Birth PLEASE PRINT (Patient's Name)

TO BE COMPLETED BY CHAMBERS & BLOHM IF NO ACKNOWLEDGEMENT CAN BE OBTAINED

Chambers & Blohm Psychological Services made a good faith effort to obtain acknowledgement from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained, was:

Patient (or authorized agent) refused to sign after being requested to do so

Notice mailed

Minor child unaccompanied by parent/legal guardian

Other: (please describe) _____

_____

Date

_____

Signature of Chambers & Blohm Psychological Services Associate

Chambers & Blohm Psychological Services
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