WELCOME TO THE OFFICE OF DR MARIO GIACOMUZZI

Please take a moment to fill out the following patient information (provide reliable contact information such as current address, home, mobile phone numbers, and email address).

Todays Date:____________________________ Referred by:____________________________________

Client Name:________________________________ ____
(Name of primary insured if not client)

Your Birthdate:_______________________________ Their Birthdate:__________________________

Are you a: Student Employed Single Married Divorced

Address:___________________________________ ____
(Primary insured address if different)

City:__________________ ST_______________ City:_________________ST_____________________

Zip:____ Zip:_______________________________________

Home PH:________________________________Insured's Employer:_________________________

Mobile PH:____

Email address:____

Insurance Company:____
(please provide copy of insurance card if using insurance and verify your benefits such as deductible, copay, or coinsurance amounts which may be different from medical benefits; Dr. Giacomuzzi is not responsible for knowing your benefits; patients are ultimately responsible for their bill and coordinating with their insurance company)

Insurance Identification #:____

Group or Policy #:____

Phone #:____

Claims Address:____
____

Primary Care Physician Name and #:____

Psychiatrist's Name and Phone #: ____

Who may we contact in case of an emergency? ____________________________________

Phone # and relationship to you?____

TREATMENT CONSENT AND INSURANCE AUTHORIZATION FORM

- I have been informed of my rights to protected health information, that Dr. Giacomuzzi will maintain my privacy and keep my records confidential. I also understand the limits of confidentiality under which my patient health information may be disclosed such as in cases of child abuse or neglect, and safety issues such as suicidal or homicidal intent. ________(initial)

- I authorize Dr. Giacomuzzi to release any demographic, diagnoses, and procedural information about myself or my dependent/s, to my insurance carrier in order to process behavioral health claims on my behalf. I understand that this information may be released to a third-party payor having responsibility for payment of charges, review agents, and/or managed review agents, and is protected by Health Insurance Privacy Laws.
_______(initial)

- I understand that I am responsible for payment at the time of service (exception for minors). If insurance is being billed, I am responsible for copays, coinsurance and/or unmet deductibles. I am also ultimately responsible for verifying my insurance benefits (copays, coinsurance, deductible, preauthorization) and to make sure that behavioral health treatment is a covered benefit under my plan. _______(initial)

- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account and for any professional services rendered. I have completed all of the attached information, provided accurate and up-to-date insurance information. If I am not the primary insured, it is my responsibility to coordinate with the primary insured (for example ex-husband/wife or step-parent).
________(initial)

- I am aware that I need am financially responsible for late cancellations or failed appointments. With the exception of sudden illness or emergency, <u>a minimum of 24 hours is required to avoid being charged for the full session fee</u>. If I have 3 or more late cancellations or failed appointment, therapy sessions may be terminated and I may be referred to another provider.
________(initial)

- I understand that if my account becomes delinquent of at least 6 months, I may be charged late payment fees up to 15%, and that I am responsible for any collection or legal fees if needed to obtain payment of my account.
_________(initial)
- I understand that I may review or inspect the information to be disclosed to insurance companies can revoke or withdraw this consent at any time.

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Patient/Parent/Guardian/Guarantor Signature: **Date:**

CREDIT CARD AUTHORIZATION FORM

<u>Please provide Credit Card Information to be kept on file, if using this payment option:</u>

Card Type: **Visa** **MasterCard** **Discover**

Name on Card:_________________________________ Zipcode:________________

Card #____ Expiration Date:__________

Security Code (3 digit code on back of card)_____________

Signature Authorizing use of Card for Payment: ___________________________________

Email address where receipt can be sent:____

Please note that the above information will be used only for the purpose of treatment costs (e.g. copays, deductibles, coinsurance, late cancellations, and/or failed appointments) and that the above signature authorizes such charges to be made when appropriate.