Redwood PsychAlliance, Inc.

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Sex:	DOB:
			❑ Male ❑ Female	/ /

Social Security No.:	Home Phone Number:	Cell Phone Number:
_ _	( )	( )

Address:

P.O. Box:	City:	State:	ZIP Code:

Mother: (if minor)	Father: (if minor)

Email Address:

INSURANCE INFORMATION

Do you have any Medicare or Medi-Cal Insurance Coverage? ❑ **YES** ❑ **No** (**WE DO NOT SUBMIT/CONTRACT WITH EITHER**)

Person responsible for bill:	Birth Date:	Address (if different):	Home Phone Number:
	/ /		( )

Cell phone no.: ( ) **Work phone no.:** ( )

Is this patient covered by insurance? ❑ **Yes** ❑ **No**

Name of Insurance Co.: **Insurance Telephone No.:** ( )

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
		/ /			

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name	Relationship to patient:	Home Phone Number:	Cell Phone Number:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician/clinician. I understand that I am financially responsible for any balance. I also authorize Redwood PsychAlliance, Inc. or Insurance Company to release any information required to process my claims.

Patient/Guardian Signature **Date**

Redwood PsychAlliance, Inc.

2200 Range Avenue, Suite 200 ● Santa Rosa, CA 95403
(T) 707.568.1101 / (F) 707.568.1103

TREATMENT AGREEMENT with: □ **Bonnie Beem, LMFT** □ **Elaine Greenwood, LMFT** □ **Robert Greenberg** □ **Shannen Fraley, LMFT**

Services Provided

Psychotherapy sessions are 50-minutes long unless otherwise agreed upon. A different type of therapy may be suggested depending on the nature of severity of your concerns. I do not provide emergency/crisis or 24-hour coverage. If you have an urgent problem, please call 911 or Sonoma County Psychiatric Services at 707.576.8181 or go to the nearest hospital emergency room. You may leave me a non-urgent message at the number below and I will return it as soon as possible.

Cancellations

In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hours in advance of your appointment. You will be responsible for the full fee (not just your co-payment) for missed or late cancellation appointments.

Payment

Please check if your therapist is In-Network with your insurance prior to your 1st appointment. Redwood PsychAlliance (RPA) currently directly bills **only** the following insurances: Aetna, Anthem Blue Cross, Magellan, MHN, United Behavioral Health/Optum Behavioral Health and Beacon Please tell the office prior to your first appointment if you have Medicare/Medicaid or Medi-Cal; even if you have a supplemental insurance plan. We do not bill for Medicare/Medicaid or Medi-Cal. Payment is expected at the beginning of each session. Fees can be paid by cash, check or credit/debit cards (on file). For your convenience, overdue balances and co-pays may be billed directly to credit/debit cards. If you wish to use a credit/debit care, be sure to fill out the Credit Card form in the new patient packet. If your check is returned for insufficient or uncollected funds (NSF), your signature on your check gives us permission to debit your checking account electronically for the uncollected amount. We will also charge you for the NSF fee billed to us by our bank. Payment by check constitutes your acceptance of these terms.

Records or Reports

I will provide letters and reports to outside sources with your authorization. Reports and forms take time to produce there is a charge of $10 minimum at the providers' discretion. Records with your authorization can be faxed or copied for a fee of $20 after 20 pages it will be .10¢ per page.

Terminations or Transitions of Care

The length of your treatment and the time of the eventual termination of your treatment depends on the specifics of your unique situation and the progress you achieve. It is a good idea to plan for termination as you approach the completion of your treatment goals.
You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. These may include referral, changing your treatment plan or terminating therapy. It is always important to discuss feelings about the progress of therapy while in session.

Confidentiality Policy

All communications between therapist and client will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participate in the treatment with you provide their written authorization to release information. In addition, I will not disclose information communicated privately to me by one family member, to any other family member without written permission.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. Parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I may exercise my professional judgment and discuss the treatment progress of a minor client with the parent or caretaker.

There are state mandated exceptions to confidentiality: cases of suspected child or elder abuse, intent to harm self or others, or when information is required by law or ordered by the court.

I, _____ have read, understand and agree to abide by the terms of the treatment contract outlined above.

(PRINT NAME OF PATIENT OR GUARDIAN)

Signature: _____ Date: _____

(PATIENT OR GUARDIAN)

Therapists Contact Numbers

Bonnie Beem, MFT	(707) 583-3483 (cell)
Elaine Greenwood, MFT	(707) 575-4058 (cell)
Robert Greenberg, MFT	(707) 579-5928 (office)
Shannen Fraley, LMFT	(707) 953-4110 (cell)

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MISSED / NO SHOW / LATE CANCELATION POLICY

DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELED APPOINTMENT(S).

I understand and agree to the following:

(1) It is my responsibility to notify my provider at Redwood PsychAlliance, Inc., 24 hours prior to the scheduled appointment time, if I am unable to keep the scheduled appointment.

(2) I agree that I will be billed the **full** fee in the event that I/ or my child miss an appointment or fail to cancel 24 hours prior to the scheduled appointment.

The full fee as follows:

LMFT: $60

_____ _____

PATIENT NAME (PRINT) **REPRESENTATIVE/ PARENT OR GUARDIAN (IF MINOR) (PRINT)**

_____ _____

PATIENT SIGNATURE **REPRESENTATIVE/ PARENT OR GUARDIAN SIGNATURE**

_____

DATE

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Acknowledgement of Receipt of Notice of Privacy Practice

The HIPPA is posted on the website and in the waiting room.

I, _____, have received a copy of Redwood PsychAlliance, Inc. Notice of Privacy Practices.

_____ _____

PATENT NAME (PRINT) **RESPONSIBLE PARTY/PARENT OR GUARDIAN (IF MINOR)**

_____ _____

PATIENT SIGNATURE **RESPONSIBLE PARTY/ PARENT OR GUARDIAN SIGNATURE (IF MINOR)**

_____

DATE

IT IS YOUR RIGHT TO REFUSE TO SIGN THIS DOCUMENT

FOR OFFICE USE ONLY:

The reason that a standard acknowledgement if the receipt of the Notice of Privacy Practices was not obtained:

□ Patient/ Representative/ Parent or Guardian refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented this office from obtaining it

□ Other: _____

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SIGNATURE ON FILE

(PLEASE INITIAL EACH BOX)

☐ I authorize the doctor or clinician to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.

☐ I authorize release of any information related to any claims to all my insurance companies or other relevant parties.

☐ I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.

☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

☐ I authorize payment of health benefits otherwise payable to me, directly to my doctor/clinician.

☐ I permit a copy of this authorization to be used in place of the original.

☐ This "Signature on File'' is valid for one year from the dated indicted below.

_____

NAME OF PATIENT (PRINT)

_____

SIGNATURE OF PATIENT /REPRESENTATIVE OR LEGAL GUARDIAN (IF MINOR)

_____

DATE

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FEE SCHEDULE

INITIAL EVALUATION: (Non Insurance)

$150 (LMFT)

FOLLOW UP (60 MINUTES): (Non Insurance)

$120 (LMFT)

LATE CANCELATION / MISSED / NO SHOW APPOINTMENT FEE:

$60 (LMFT)

REPORT/ FORMS/LETTER(S):

$10 minimum @ Provider's discretion

RECORDS:

$25 minimum (.10¢ per page after 20 pages)

INSUFFICIENT FUNDS:

$25 per check returned to Redwood PsychAlliance, Inc.

_____ _____

Patient Name (PRINT) **Responsible Party/Parent/Guardian (If Minor) (PRINT)**

_____ _____

Patient Signature **Parent/Guardian Signature (If Minor)**

_____

DATE

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FINANCIAL AGREEMENT

REGARDING INSURANCE ASSIGNMENT:

- We will only file claims with insurance companies we are contracted with. In order to achieve this, we must have all current insurance information on file.
- If there are any changes in your insurance coverage, you must notify RedwoodPsychAlliance, Inc. prior to your next appointment**.**
- The patient must stay current with the payment of their deductibles and co-payments. All information this office gives in reference to your insurance coverage is based on information obtained from your insurance company. It is only descriptive of your benefits, and is not a guarantee of payment by your insurance company. An insurance company may quote benefits and give authorization, but clearly state in their disclaimer this is not a guarantee of payment. Therefore, any amount we collect at the time of service or quote as your responsibility is any estimate only. You are ultimately responsible for any and all balances on your account.

The patient receiving treatment from Redwood PsychAlliance, Inc. agrees to: (PLEASE INITIAL EACH BOX)

☐ I AM RESPONSIBLE FOR ALL EXPENSES INVOLVING MY TREATMENT.

☐ PAYMENT OF CHARGES IS DUE AT THE TIME OF THE APPOINTMENT BY CASH, CHECK OR CREDIT/DEBIT CARD.

☐ IF REDWOOD PSYCHALLIANCE, INC. FILES CLAIMS ON MY BEHALF, I AGREE TO PAY FOR NON-COVERED INSURANCE BENEFITS, CO-INSURANCE AND DEDUCTIBLES.

☐ IF MY MINOR CHILD IS BEING TREATED I AM REQUIRED TO SEND PAYMENT IN **AT THE TIME OF SERVICE OR HAVE A CURRENT CREDIT CARD ON FILE.**

☐ I GIVE REDWOOD PSYCHALLIANCE, INC. PERMISSION TO USE MY CREDIT CARD ON FILE FOR ANY CHARGES DUE ON MY ACCOUNT.

CREDIT CARD:	
CREDIT CARD #:	
CREDIT CARD EXP:	
NAME ON C/C:	
BILLING ADDRESS:	

_____ _____

Patient Name (PRINT) **Responsible Party Name (PRINT) (Parent/Guardian of Minor)**

_____ _____

Patient Signature **Parent/Guardian Signature (If Minor)**

_____

DATE