

# Collaborative Care of Abington

1369 Old York Road, Abington, PA 19001

## Consent for Treatment

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt. # P.O. Box City State Zip

Social Security Number: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Please Indicate Number for Confidential Messages: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Other: \_\_\_\_\_

Sex: Male: \_\_\_\_\_ Female: \_\_\_\_\_

Employed: F.T. Student \_\_\_\_\_ P.T. Student: \_\_\_\_\_ Disability: \_\_\_\_\_ Other: \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Email Address: \_\_\_\_\_

Guarantor's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Relationship to Guarantor: Self: \_\_\_ Spouse: \_\_\_ Dependent: \_\_\_ Child \_\_\_ Other \_\_\_

Guarantor's Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Guarantor's Social Security Number: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Primary Insurance Company: (Please provide copy of insurance card)

I.D. Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance Company, if any: (Please provide copy of insurance card)

\_\_\_\_\_ Group Number: \_\_\_\_\_

### Consent to Charge Insurance Company

I, (Patient's Signature) \_\_\_\_\_, authorize *Collaborative Psychiatric Associates*, to release health care information necessary to process any insurance claims to my insurance carrier. This information is to be used for purposes of continuity of care, authorization of sessions and billing only. I understand that this information may also required by my insurance carrier for administrative purposes.

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I understand that failure to agree to the release of this information may affect *Collaborative Psychiatric Associates'* ability to collect payment under my insurance plan and I will be responsible for payment at private or out-of-benefit rates (\$80-\$150 per session, depending on service provided). In addition, if my insurance carrier denies payment for any reason, I assume responsibility for the cost of the sessions at standard private rates.

\_\_\_\_\_ *Initials*

All insurance co-pays or private rate payments **MUST** be paid by the client at the time of the visit. We accept cash, personal checks, Visa, MasterCard, Discover & American Express.

\_\_\_\_\_ *Initials*

If I need to cancel, I will give *Collaborative Psychiatric Associates* **24 hours notice**. A cancellation fee of \$55.00 will be charged and is NOT covered by insurance. This fee will be waived by the clinician if they honor the situation as an emergency.

\_\_\_\_\_ *Initials*

I understand that this consent shall remain in effect for one year or throughout the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above named treatment provider and my insurance carrier.

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature (If minor, signature of parent or guardian)

\_\_\_\_\_ Date: \_\_\_\_\_  
Witness (Therapist under contract with insurance carrier)

***\*\*\*I have received and read a copy of "Notice of Collaborative Care of Abington Policies and Practices to Protect the Privacy of Your Health Information."\*\*\****

\_\_\_\_\_ Name (Signature) \_\_\_\_\_ Date

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\_\_\_\_\_ Copy of Insurance Card (Front & Back)

\_\_\_\_\_ Co-pay Amount

\_\_\_\_\_ Deductible/Co-insurance amount if applicable

\_\_\_\_\_ Additional Information  
\_\_\_\_\_  
\_\_\_\_\_

Clinician's Signature: \_\_\_\_\_