Mark Levinsky, LMHC
7301 W. Palmetto Park Rd., Suite 104B
Boca Raton, FL 33433-3456
Phone 561-368-9940 FAX 561-423-2609

REFERRAL NUMBER_____

PATIENT INFORMATION

PLEASE PRINT CLEARLY DATE_____

PATIENT NAME _____ PATIENT'S DATE OF BIRTH _____ SEX____

PATIENT'S ADDRESS _____ CITY_____STATE____ZIP_____

EMAIL ADDRESS OF SELF OR REPONSIBLE PARTY_____

HOME PHONE NUMBER ( ) _____ WORK PHONE NUMBER ( ) _____EXT____

PATIENTS OCCUPATION_____REFERRED BY_____

PERSON TO CONTACT IN EMERGENCY_____PHONE_____

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INSURED SUBSCRIBER _____ PHONE NUMBER _____ RELATIONSHIP TO PATIENT _____

D.O.B. OF SUBSCRIBER _____ ADDRESS OF SUBSCRIBER _____

CITY_____ STATE____ ZIP_____ EMAIL_____ OCCUPATION_____

NAME OF FIRM SUBSCRIBER EMPLOYED BY_____ PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE ____ ZIP _____

MARITAL STATUS _____ SUBSCRIBER S.S.N. _____ OCCUPATION _____

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NAME OF INSURED_____

MEDICAL INSURANCE CO._____ID.NO._____

GROUP NO._____CODE NO._____STREET_____

CITY_____STATE_____ZIP_____

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NAME OF INSURED_____

MEDICAL INSURANCE CO._____ID.NO._____

GROUP NO._____CODE NO._____STREET_____

CITY_____STATE_____ZIP_____

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WORKER'S COMP. INS. CO._____CITY_____

EMPLOYER AT TIME OF INJURY_____CLAIM #_____

FIRST REPORT FILED?_____BY WHOM?_____DATE INJURED_____

FINANCIAL POLICY

Thank you for choosing Mark Levinsky, LMHC as your provider. We are committed to your treatment being successful. **The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment:**

Payment Policy

You are responsible for payment of treatment **at the time services are rendered**, unless we agree otherwise, including any co-payments and/or a deductible if applicable. An adult accompanying a minor, be it a parent or guardian, is responsible for payment.

Mark Levinsky, LMHC, agrees to provide psychotherapy, training, and/or psychological or neuropsychological testing at the rate of _____ per session, per hour, or per testing battery (circle one that applies). Each psychotherapy session normally lasts 45-50 minutes. Mark Levinsky, LMHC does not accept insurance unless we are providers. We will gladly print out a claim form so that you may submit it to your insurance for possible reimbursement. Please bear in mind that many insurance companies do not pay for testing or only pay for a portion. If testing is to be done, payment must be made in full **prior** to the final feedback session, while at least half the charge is due when the face-to-face testing is complete. Without proper payment, a report will not be released. Other services in which there is a hourly fee include report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. Additionally, telephone conversations lasting longer than **10 minutes** are billed on a prorated basis of the hourly fee (of individual therapy or testing). If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time. The fee schedule for preparation and attendance at any legal proceeding is included in another paper and will be presented when necessary.

If you issue bad checks, you will be responsible for the original amount of that check plus a charge of $10 per check.

You are directly responsible to Mark Levinsky, LMHC for all bills submitted to you for services rendered by Mark Levinsky, LMHC to you (or your child).

Payment of the bills submitted is not contingent on any settlement, judgment, or insurance payment by which you may eventually recover the fees.

If a third party, such as an insurance company, is to cover part of the fee that all phone calls or mailings made to verify the coverage or to inquire about or secure payment may be charged to your account.

Please be aware that there are no free initial consultations.

Please note: It is understood by the undersigned that any outstanding balance past 60 days will be subject to financial charges and the account may be forwarded to a collection agency, a credit reporting bureau, and/or small claims court. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of the services provided, and the amount due. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. If a lawsuit is filed against the undersigned, then he/she will be responsible for court costs as well. Overdue balances are subject to a finance charge of 1 and ½ % per month. We accept cash, check, and most major credit cards.

Insurance Patients

If your therapist accepts assignment from your insurance carrier, we will be happy to process claims directly to your insurance company. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees, regardless of whether your insurance company pays or not. It is very important that you find out exactly what mental health and neuropsychological services (if applicable) your insurance policy covers. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance paid for by your insurance. If the insurance company does not cover the expected payment for time or services rendered by the Corporation, you agree that you are responsible for full payment of these services, within 30 days of the date of service. With insurance companies and policies constantly changing, including Cobra coverage, you must verify with your insurance company that you are covered under psychiatric or psychological/mental health care. If you do not notify the Corporation or any of its representatives that your insurance status has changed in any fashion or notify them late, you will be responsible for the full normal fee paid to the provider, up to the date of notification, if it applies.

You should be aware that your contract with your health insurance company requires that we provide it with information relevant to the services provided to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purposes requested. This information will become part of the insurance company files. Although all insurance companies claim to keep such information confidential; the Corporation has no control over what they do with it once it is in their hands. By signing this Agreement, you agree that we can provide any requested medical, psychological and/or neuropsychological information to your carrier or its agents, if required for determination or payment of benefits.

If you have an HMO insurance policy you must let the office know before you are seen. You also must obtain pre-authorization from the insurance company prior to being seen. Pre-authorization is absolutely essential before being seen with HMOs. ***Your insurance policy is an agreement between you and your insurance company; we are not party to that contract.*** If you do not follow these policies you agree to be responsible for all outstanding balances. It is your responsibility to know the limits of your policy, not us.

Missed Appointments

Unless cancelled at least 24 hours in advance, **you will be charged for a missed appointment. Please refer to our CANCELLATION POLICY for further details.** We ask you to help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

PATIENT NAME: _____

By the presence of my signature, I state I have read and understand the Financial Policy and agree this constitutes a contract between myself, and Mark Levinsky, LMHC and its representatives and give my consent to services as recommended by and in accord with Mark Levinsky, LMHC:

_____ _____

Signature of Responsible Party Date

INSURANCE PATIENTS ONLY

INSURANCE ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO THERAPIST

I, _____ hereby instruct and direct _____
PATIENT NAME NAME OF INSURANCE COMPANY

to pay by check made out to and directly mailed to:

Mark Levinsky, LMHC
7301 W. Palmetto Park Rd., Suite 104B
Boca Raton, FL 33433-3456

If my current policy prohibits direct payment to said doctor/assignee, then I hereby also instruct and direct you to make out the checks to me and mail it as follows:

> The professional or medical expense benefit allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance said professional service charges over and above this insurance payment.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize the exchange of any information pertinent to my case between Mark Levinsky, LMHC and my insurance company, adjustor or attorney involved, regarding issuing payments for these services.

Dated this _____ day of _____, 20_____.

_____ _____
Signature of Policy Holder Witness

_____ _____
Signature of Claimant if other than Policy Holder Witness

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CANCELLATION POLICY

PATIENT: _____

The fee that you pay for treatment/testing represents your commitment to improve your life. It is an important responsibility that you assume and one that is honored. When you schedule an appointment, that clinical hour has been set aside for you. If you choose to cancel that time, as stated in our **FINANCIAL POLICY**, we must have 24 hour notice, unless of course there is a serious emergency.

If this condition is not upheld, **you will be charged $60 for Psychotherapy session. If you are using benefits through an Employee Assistance Program (EAP), we will notify your EAP program and you will lose a session available to you.**

As a courtesy, we frequently try to confirm your appointments the day before by phone, but the ultimate responsibility is yours to be sure you are here on your scheduled day and time.

I have read and understand the above cancellation policy.

_____ _____
Patient Signature or Legal Parent/Guardian Date

_____
Relationship to Patient

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that Mark Levinsky, LMHC has made the Notice of Privacy Practices available to me, and I have been given the opportunity to review it. I understand that a copy is available to me upon my request.

Further, I understand that Mark Levinsky, LMHC will use my information as described therein, unless I request otherwise.

Name _____

Signature _____

Date _____