**Cyd Laurel, LLC**

## REGISTRATION INFORMATION

Date:________________________ Phone:________________________________________

Client:____________________________________________________ 2nd Phone:_____________________________________

Client's Social Security #:___________________________________________

Responsible party:__________________________________________ Relationship to client:_____________________________

Responsible party social security #: ___________________________ Responsible party birthdate: _______________________

Home Address:_____________________________________________ Email:_____________________________________________

City:________________________________ State:_____________________ Zip code:___________________

Date of birth:_________ Age:_____ Gender:______ Marital/partner status: __________________________________________

Purpose of visit:_____________________________________________________________________________________

Client Employer/School: _____________________________________________________________________________

Employer/School Address: ______________________________________________________________________

Employer/School Phone:__________________________________ Occupation:_________________________________

Responsible party employed by: _____________________________________________________________________

Employer's address: ___________________________________________________________________________

Employer's Phone: ______________________________ Responsible party occupation: __________________________

Do you have Medical insurance? ______ If yes: Name of Primary Insurer:____________________________________________

Contract# ___________________________ Group# ______________________ Subscriber#___________________________

Name of Secondary Insurer: ________________________________________________________________________________

Contract#___________________________ Group# _______________________ Subscriber# __________________________

Medicare or Medicaid (circle one) Claim ID # ______________________________________________________

Who should be notified in case of emergency? __________________________ Phone: _______________________________

How did you hear of this practice? __________________________________________________________________________

## INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with ______________________________________________

and assign directly to Cyd Laurel, LLC all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions. The above named practitioner may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed.

____________________________________________________________ ____________________

Signature of Responsible Party Date

# Cyd Laurel, LLC

**1446 South Reynolds Road, Suite 215, Maumee, OH 43537**
**419 283 6958**

## FINANCIAL POLICIES

**Fees and Financial Arrangements**: The practice fee schedule is competitive with other area practices. Please bring your insurance card with you at the time of your visit. If a referral is necessary from your primary care physician, please confirm it is in place prior to your visit. Please assure that you provide notice of any changes in insurance coverage during your course of therapy. You will be responsible for any charges incurred during lapse of coverage. Please be aware that having insurance benefits does not guarantee payment. Your insurance carrier may review your claim(s) and base their decision regarding payment on diagnosis, medical necessity, pre-existing conditions and other contractual restrictions. Cyd Laurel, LLC will assume no liability for denial of claims. *All counseling and service relationships are made with the client or their responsible party and not the insurance carrier.*

**Insurance co-pays:** You may pay your co-pay at the time of service with cash or check.

**Self Pay:** Self pay clients may pay for services at the time they are rendered or make other arrangements with the Practice Manager.

**Payment of Account Balances:** You will receive a monthly statement depicting client balance owed and the amount outstanding to your insurance carrier. Please remember that the agreement for treatment is made between you and your practitioner, not your insurance carrier. *You are responsible for all billed charges.* Please contact the Practice Manager to make payment arrangements.

**Cancellation Policy:** ***There will be a $25 charge for appointments not cancelled within 24 hours.*** This courtesy makes it possible for another client to be seen. Your insurance does not cover charges for cancelled/missed appointments.

## CONSENT FOR TREATMENT

I acknowledge that my/my dependent child's treatment relationship is voluntary. I agree to my/my dependent's child's treatment as defined in the treatment plan. Risks and benefits of treatment have been explained to me. If I choose to disrupt treatment, I can request referrals to comparable services.

## PRIVACY PRACTICES

Your relationship with Cyd Laurel, MA, PCC-S and/or Cyd Laurel, LLC is a protected relationship. Information about your treatment cannot be provided to others without your consent unless you pose a clear and imminent threat to yourself/others or are abusing a child or elder.

## YOUR TREATMENT RIGHTS

- The right to obtain a paper copy of this notice.
- The right to inspect and copy your health information unless documented to be detrimental to your mental health
- The right to request to amend information in your record you believe to be inaccurate.

- The right to obtain an accounting of our uses and disclosures of your mental health information, subject to certain exceptions.
- The right to request restrictions on our permitted uses and disclosures of your information (although this may not be a legal obligation).

**Practitioner responsibilities:** I am required by law to maintain the privacy of your mental health information.

## ACKNOWLEDGEMENT

I, ___________________________________________acknowledge receipt of the Financial Policies, Insurance Disclaimer, Consent for Treatment and Notice of Privacy Practices.

**Signature: __________________________________ Date: _________________________________**

**Witness: ___________________________________ Date: __________________________________**

## TELEPHONE CONTACT

How may the office contact you regarding cancellations or reminders: Please call:_______________________________ and talk to ______________________________. You can cannot (circle one) leave a message.