Jennifer McCarron, LMFT
418 Stump Rd., Suite 207
Montgomeryville, PA 18936
215-361-7654

CONSENT FOR TREATMENT FORM

I, _____ understand and agree to the following:

- Treatment provided by Jennifer McCarron LMFT is voluntary in nature and I may terminate treatment at any time.
- The information disclosed during therapy will remain strictly confidential, requiring signed authorizations from all parties if information is to be shared with outside parties (with the exception of insurance companies).
- If I reveal information to my therapist indicating I may be a safety threat to myself or others, my therapist may be permitted and/or mandated by law to reveal this information to other persons or agencies for the safety of myself or others.

FEE AGREEMENT

- The fee per visit is **$125**, or the designated Co-Pay of $_____, payable at the start of each session. I understand it is my responsibility to contact the insurance company regarding my co-pay amount for each session, and that my payment (exact cash or check) is due at the start of every appointment, including the initial one.
- I am financially responsible for any amount not covered by the insurance. (Some insurance companies authorize, but no not pay for relationship and/or family therapy.)
- **I understand that 24 hours notice of cancellation is required to allow others waiting for an appointment an opportunity to be seen. If I am unable to give 24 hours notice of cancellation, I will be responsible for a $60.00 charge.**

My signature below indicates I understand and agree to the "Consent For Treatment Form" and "Fee Agreement" policies above:

Client's Signature (age 14 and over):_____ Date:_____

Parent's Signature (under 14 years): _____ Date: _____

Therapist's Signature: _____ Date: _____

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CLIENT INFORMATION FORM
(Please print)

Name(s):____

***If under 18**, parents' names____

Date of Birth__________________

Home Address:____________________ City:__________________ State:____ Zip:________

Home phone:________________ Mobile:__________________Work:___________________

Preferred number for therapist to contact you: ______________________________________

Can I leave messages for you regarding appointments at the numbers above? Y____ N____

If no, please indicate any restrictions: ____

Email ______________________________________ Subscribe to Newsletter? Y____ N____

Employer/Company Name ________________________ Occupation____________________

***If Student**, Grade Last Completed ____Name of Current School_______________________

Emergency Contact _______________________ Relation to Client _____________________

Phone:_______________________

INSURANCE INFORMATION (if applicable)

Name of Health Insurance______________________ ID#_______________________

Are you the primary insurance subscriber? (Circle one) Yes No

If not, name of subscriber_________________ Relation to subscriber _______________

Subscriber's Date of Birth_____________________

Subscriber's Employer_______________________

Below for Office Use Only

- -

Insurance Co./EAP___________________________________

Initial Authorization Number___________________________

Co-payment: __________ Visits/year___________________

Nov-09 Date entered: ___________

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)