Dr. Gregg A. Pizzi & Associates, P.A.

175 SW 7 Street • Suite 1205 • Miami, Florida 33130
1-888-DRPIZZI • DrPizzi@DrPizzi.com • www.DrPizzi.com

CLIENT INFORMATION

Account # _____
(OFFICE USE ONLY)

NAME: _____ DATE: _____

PARTNER/SPOUSE NAME (if Relationship Therapy): _____

BIRTHDATE: _____ SS# _____

GENDER: _____ RELATIONSHIP STATUS: _____ AGE: _____

U.S. MAIL

By providing your address and your signature on this form, you give authorization for this office to send correspondence via U.S. mail to the address below.

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE

Please provide telephone numbers only if you give authorization for this office to both call you and leave messages at the number given. If you prefer not to be called nor to receive messages at a particular phone number, do not provide it on this form.

PHONE: (H) _____ (W) _____ (C) _____

INTERNET & E-MAIL

By providing your signature on this form, you authorize the office of Dr. Gregg A. Pizzi & Associates, P.A., to store information about you and communicate with you via internet and electronic mail. While use of the internet and e-mail has many benefits such as speed of communication, ease of record-keeping, and convenience, the internet is not a secure environment and confidentiality cannot be guaranteed. Every effort is made by this office to keep your information private to the extent possible, however once information has been entered online or an e-mail has been sent, the information may be accessed by individuals other than the intended recipient(s) and is no longer under the sender's control. E-mail systems often store e-mail interactions, and e-mails sent from a personal computer may be readable by any individual with access to that computer. In providing an e-mail address, it is recommended that you choose a personal one that you do not share with other individuals, although this office

CLIENT INFORMATION

may reply to you via any other e-mail address from which you may initiate a communication. You agree to keep private your e-mail password(s), e-mail account(s), Online Appointment Scheduler password, and online profile, and not to share this information or allow access to anyone.

E-MAIL ADDRESS: _____

This office utilizes AppointmentQuest Online Scheduling Software for the purposes of scheduling appointments, information storage, payment processing, and service-related communication with patients and clients. Insurance claims are processed via the internet by EClaims, Inc., an electronic claims processing service. If you make payment by credit/debit card, the transaction will be processed via the internet by Authorize.Net and/or ProfessionalCharges.com.

OCCUPATIONAL INFORMATION

OCCUPATION: [ ] Employed [ ] Student [ ] Unemployed
[ ] Self-employed [ ] Homemaker [ ] Retired

WORK/SCHOOL NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK/SCHOOL PHONE: _____ HIGHEST GRADE COMPLETED: _____

MISCELLANEOUS

REASON FOR VISIT: _____

REFERRED BY: _____

Do you give Dr. Pizzi permission to thank this individual/agency for referring you(if applicable)? [ ] YES [ ] NO

EMERGENCY CONTACT (or Parent/Guardian): _____

RELATIONSHIP TO CLIENT: _____ PHONE: _____

PAYMENT INFORMATION

[ ] Client is solely financially responsible for this account
[ ] *Individual Responsible for Payment* is named below:

INDIVIDUAL RESPONSIBLE FOR PAYMENT: _____

RELATIONSHIP: _____ SS# _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (H) _____ (W) _____ (C) _____

CLIENT INFORMATION

PAYMENT TYPE: (Check all that apply)

[ ] Standard Payment (Pay fee at time of service)
[ ] Participating Provider Insurance (Pay copayment at time of service)
[ ] Out-of-Network Insurance (Pay fee at time of service; claims submitted by office)
[ ] Pre-Payment Option (Inform psychologist of number of sessions desired)
[ ] Other: _____

NAME OF INSURANCE COMPANY OR OTHER PAYOR: _____

ADDRESS: _____ PHONE: _____

MEMBER NAME (Insured individual, if other than Client): _____

RELATIONSHIP TO CLIENT: _____ MEMBER BIRTHDATE: _____

MEMBER ID # _____ GROUP # _____ COPAY: $ _____

DEDUCTIBLE: $ _____ COVERAGE: _____ % VISITS MAX: _____

RELEASE AUTHORIZATION

I authorize Dr. Gregg A. Pizzi & Associates, P.A., its members, employees, or agents acting on its behalf, or any holder of psychological, medical, or other information about me, to release to EClaims, Inc., the Social Security Administration, the Center for Medicare and Medicaid Services (CMS), the *Individual Responsible for Payment* named above, my insurance company or other payor, or their intermediaries or carriers, any information necessary to obtain authorization for, to process claims for, or to secure payment for, services rendered under this agreement. I permit a copy of this authorization to be used in place of the original, without obtaining my signature on each and every claim, and agree to be bound by the signature as though I had signed the particular claim. I request that payment of authorized benefits be made to Dr. Gregg A. Pizzi & Associates, P.A., on my behalf. I authorize payment of medical or psychological benefits for services rendered under this agreement to Dr. Gregg A. Pizzi & Associates, P.A.

FINANCIAL AGREEMENT

I understand that I am expected to pay Dr. Pizzi's full fee for each service at the time of the appointment, unless services have been pre-paid or my insurance coverage requires another arrangement. I understand that I am responsible for any and all charges not covered by my insurance company or other payor, including, but not limited to: (1) any amounts applied to the deductible; (2) any copayment amounts; (3) charges for services that are not covered by my insurance company or other payor; (4) charges that are denied by my insurance company or other payor; and (5) the difference between the portion paid by my insurance company or other payor and the standard fee charged by this office (unless prohibited by contract). I understand that the designation of an *Individual Responsible for Payment* does not relieve the patient or client of any financial obligation to this account, and that the patient or client may be held ultimately responsible for payment. I understand that if any portion of this account has not been paid for ninety (90) days, legal means may be used to secure payment. I also understand

that a *Missed Session Charge*, equal to the full standard fee for the scheduled service, will be assessed for no-shows or appointments canceled with less than 48 hours' advance notice.

INFORMED CONSENT

My signature below indicates that I have received and reviewed a copy of the HIPAA Notice (the *Notice*). I have also received a copy of the Psychological Services Agreement (the *Agreement*). I will review the *Agreement* in its entirety prior to my next appointment, so that any questions or concerns I have may be addressed prior to my agreeing to it in writing.

I hereby voluntarily agree and consent to receiving psychological services from Dr. Gregg A. Pizzi & Associates, P.A. I understand that: (1) there are both risks and benefits associated with receiving psychological services; (2) there may be alternative treatments available for my condition; and (3) there are limits to the confidentiality of what I may tell the psychologist. These issues are explained in detail in the *Agreement*. I further understand that I may withdraw my consent and discontinue my participation at any time.

My signature below indicates my understanding of and agreement with the above, and my promise to abide by the policies put forth in this *Client Information* form. I have been given an opportunity to ask questions about this form and to have any concerns explained to me prior to my agreeing to it in writing.

_____ _____

CLIENT Signature Date

_____ _____

PARENT/GUARDIAN Signature (if applicable) Date

_____ _____

INDIVIDUAL RESPONSIBLE FOR PAYMENT Signature (if different from Client) Date

(OFFICE USE ONLY) Account # _____

Dr. Gregg A. Pizzi & Associates, P.A.

_____ _____

Gregg A. Pizzi, Psy.D.
Director & Licensed Psychologist Date