Integrative Psychiatry Client Information Form

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home / Cell: _____ Work Phone: _____

Leave Message at Home? ☐ Yes ☐ No Leave Message at Work? ☐ Yes ☐ No

SSN# _____ Referred by: _____

Employee Name: _____ Medical Practioner: _____

Insurance Information

Insurance Company: _____ Phone: _____

Policy# _____ Group# _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Policy Holders Name: _____ Policy Holders DOB: _____

Seconday Insurance: _____ Phone: _____

Policy# _____ Group# _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Policy Holders Name: _____ Policy Holders DOB: _____

Financial Policy

*Payment for services is due at time services are rendered. We accept cash and most major credit cards. Checks are only accepted with proper ID and advance staff approval.
*There is a 25.00 returned check fee.
*There is a $25.00 fee billed to you not your insurance company for failure to keep appointments without giving 24 hours notice of cancellation.
*As a courtesy to you we will bill your insurance company. However, you are responsible for the charges if they do not pay.

Consent to Treatment

I _____ am requesting to receive treatment from Valerie Balandra ARNP, BC. I have been informed of the nature and purpose of this service, and that my consent can be revoked at any time. No guarantee or assurance has been made to me as to the results that may be obtained from theses services. This is a release of any and all liability to Integrative Psychiatry and its practitioners and staff from any decisions or actions I may or may not take as a result of the treatment I receive at this center.

_____ _____
Signed By Date

I agree that my information my be released to the insurance company, and my primary care physician to the extent necessary to obtain payment.

_____ _____
Signed By Date

I request and authorize payment of any insurance payment of benefits I am entitled be paid directly to Valerie Balandra ARNP, BC.

_____ _____
Signed By Date

Insurance is a method of reimbursing you for fees paid to your treatment provider and is not a subsitute for payment to this center. Some companies pay fixed allowances or a percentage of allowable charges. It is your responsibility to pay any deductible amount, co-payment or any other balance not paid by the insurance. I have read the above statement and agree to pay any charges not paid by my insurance company.

_____ _____
Signed By Date