WOODVIEW
Psychology Group

Please complete ALL sections for person receiving services.

Patient's First Name	Middle Initial	Last Name
Preferred Name		
Marital Status		Sex
Birth Date		Social Security Number
Responsible Party (Guarantor)*		Relationship

**This is the person responsible for paying for services. If the patient is 18 or older, this MUST remain the patient. If Guarantor does not accompany patient to appointment, arrangements must be made with Woodview to guarantee payment at the time of service.*

Patient's Mailing Address	**Guarantor's MAILING ADDRESS**
Street Address	Street Address
City, State, ZIP	City, State, ZIP

Main Phone	**Phone 2**	**Phone 3**
Landline Work Cell Phone	Landline Work Cell Phone	Landline Work Cell Phone
( ) ________ - _______________	( ) ________ - _______________	( ) ________ - _______________

Home Email
________________________________@_______________

Work Email
________________________________@_______________

Email to be used to for secure portal account: Home Email Work Email

Mobile number to be used for appointment reminders by text:
( ) ________ - ________________________

Do not remind me of appointments

Emergency Contact	Relationship
Emergency Contact Phone	

Insurance Company		
Subscriber	Subscriber's Date of Birth	Relation to subscriber
ID Number	Group Number	

Please provide a copy of your insurance ID card, even if you do not plan on filing.

FINANCIAL AGREEMENT I understand that I am responsible for all charges for services provided by WPG. I will pay in full, at the time of service, for all services rendered on my behalf or my dependent's behalf. WPG will provide a Billing Statement that I can file with my insurance provider for reimbursement.

____ ____________________________________

Signature of Guarantor Date

Your signature below indicates you have read and agree to the following:

CONSENT TO TREAT

I hereby request and authorize Woodview Psychology Group, LLC (hereafter referred to as "WPG") and its respective personnel to provide mental health services/treatment to me or my dependent (if patient is a minor). I understand that mental health services/treatment may include psychological assessment and/or psychotherapy. I am agreeing only to those services that WPG is qualified to provide within the scope of the provider'(s) license, certification, and training or the scope of those provider(s) directly supervising the services received by me. I also understand that, at any time, I can terminate this consent for treatment by putting such request in writing.

FILING WITH INSURANCE

It is important to understand your insurance benefits for mental health. Services provided by WPG are considered "out of network" with most insurance plans. While some plans may partially reimburse for these services, many do not. Your health insurance plan is a contract between you and your insurance company. Payment is due at the time of services. If requested, WPG will courtesy file a claim to your insurance company. Any covered services and subsequent payment will be paid to the subscriber, not WPG. If you feel that insurance should have paid the claim, it is your responsibility to contact them directly to have the claim reprocessed. You agree to provide accurate and updated healthcare/insurance information to WPG and hereby give consent to WPG to release any required information to my healthcare insurance to assist in processing claims, including protected healthcare information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

NOTICE OF PRIVACY POLICIES

I hereby acknowledge that I have been offered a copy of the "Notice of Privacy Policies" and understand the information included in this document. I am aware that a copy of this notice will be given to me when I ask for a copy.

EMAIL COMMUNICATION

Electronic communications to and from WPG should only be done through the secure patient portal account. If you choose to send email directly to your provider, you understand the risks of sending PHI through email and accept these risks.

CANCELLATION POLICY

We reserve the right to charge for missed appointments not cancelled with **48 hours' notice**. The cancellation fee will be the full fee that would have been charged for the reserved appointment type.

PSYCHOLOGICAL TESTING

If deemed necessary by your provider, psychological testing may be conducted. Psychological testing is billed hourly and includes the provider's time to conduct the testing as well as the time required to prepare a written evaluation. A deposit of $500 is required to schedule an appointment for testing. If you choose to cancel or reschedule your testing appointment with less than 48 hours' notice, you will forfeit your deposit.

Signature: ______________________________ Relationship to Patient: ________________ Date: _____________