DR LEE MORAND AND ASSOCIATES, LLC

PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____

(*First, Middle, Last*)

DATE OF BIRTH: _____AGE: _____ GENDER ASSIGNED AT BIRTH: (M) ____ (F) ____

MAILING ADDRESS **(*Street, City, State, Zip*)**: _____

_____

EMAIL ADDRESS: _____

PHONE: (H) _____ (C) _____

PRIMARY PHONE: (H) ____ (C) _____ OK TO LEAVE MESSAGE: (Y) ____ (N) _____

FACETIME PHONE ***(If different than above)***: _____

REASON FOR SEEKING SERVICES: _____

(COMPLETE IF PATIENT IS A MINOR)

CONTACT NAME: _____

PHONE: (H) _____ (C) _____

RELATIONSHIP TO CLIENT: _____

INSURANCE INFORMATION

(***A copy of your insurance card/proof of insurance is required***)

NAME OF INSURANCE COMPANY: _____

IDENTIFICATION NUMBER (***On Card***): _____

GROUP NUMBER (***On Card***): _____

POLICY HOLDER: (***Self***) _____ (***Other***) *_____

*NAME/RELATIONSHIP TO CLIENT: _____

*THEIR DATE OF BIRTH: _____ *GENDER: M _____ F _____

****Address/Phone if different from client***

*MAILING ADDRESS ***(Street, City, State, Zip)***: _____

_____

*PHONE: (H) _____ (C) _____

AUTHORIZATION

PLEASE INITIAL AND SIGN BELOW:

- I AUTHORIZE DR LEE MORAND & ASSOCIATES, LLC TO RELEASE MY MEDICAL INFORMATION TO MY INSURANCE COMPANY, REFERRING PHYSICIAN AND/OR OTHER PERSON(S) DESIGNATED BY ME: _____

- I AUTHORIZE DR LEE MORAND & ASSOCIATES, LLC TO PROVIDE ANY AND ALL NECESSARY THERAPY/TREATMENT: _____

- I AUTHORIZE MY MEDICAL INSURANCE TO MAKE PAYMENT FOR SERVICES RENDERED TO DR LEE MORAND & ASSOCIATES, LLC: _____

Signature: _____**Date**: _____

INSURANCE COVERAGE AND PAYMENT INFORMATION

IMPORTANT

THERAPY MAY BE COVERED IN FULL OR IN PART BY YOUR INSURANCE PLAN. IT IS YOUR RESPONSIBILITY TO KNOW AND UNDERSTAND THE COVERAGE AND DEDUCTIBLE AMOUNTS IF APPLICABLE OF YOUR INSURANCE POLICY. PLEASE CONTACT THE PHONE NUMBER ON THE BACK OF YOUR INSURANCE CARD (BEHAVIORAL/MENTAL HEALTH) WITH QUESTIONS CONCERNING YOUR POLICY OR REFER TO THE EXPLANATION OF BENEFITS FORM (EOB) FROM YOUR INSURANCE COMPANY.

EXAMPLES OF QUESTIONS TO ASK INSURANCE COMPANY:

- **DO I HAVE MENTAL HEALTH INSURANCE BENEFITS?**
- **DO I NEED TO MEET A DEDUCTIBLE?**
- **IS THERE A LIMIT TO THE NUMBER OF SESSIONS PER YEAR?**
- **DO I HAVE A COPAY PER SESSION?**
- **DO I NEED PRIOR AUTHORIZATION FROM MY PRIMARY CARE PHYSICIAN?**

PLEASE ACKNOWLEDGE BY INITIALING BELOW

THE CLIENT IS RESPONSIBLE FOR ANY AMOUNTS DUE (AT THE TIME OF SERVICE) THAT ARE NOT COVERED BY THEIR INSURANCE, WHICH INCLUDE COPAYS OR CURRENT INSURANCE RATES (IF MEETING A DEDUCTIBLE). **_____**
IF PAYING PRIVATELY, PAYMENT IS REQUIRED AT THE TIME OF SERVICE. **_____**

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

PLEASE ACKNOWLEDGE BY INITIALING EACH SECTION BELOW

WE REQUEST NOTIFICATION OF CANCELLATION OF **NO LESS THAN 24 HOURS** IN ADVANCE OF YOUR SCHEDULED APPOINTMENT: _____

FAILURE TO GIVE AT LEAST A 24-HOUR NOTIFICATION WILL RESULT IN YOU BEING CHARGED A FEE OF **$110**. INSURANCE COMPANIES WILL NOT PAY FOR THIS CHARGE IN THE EVENT YOU MISS AN APPOINTMENT: _____

NO FURTHER APPOINTMENTS WILL BE SCHEDULED UNTIL THE FEE IS PAID: _____

IMPORTANT INFORMATION

- TEXT MESSAGE REMINDERS ARE A COURTESY ONLY AND SHOULD NOT BE RELIED UPON AS YOUR APPOINTMENT REMINDER. PLEASE MAKE YOUR OWN REMINDERS.

- IF YOU ARE IN NEED OF IMMEDIATE ASSISTANCE THAT CANNOT WAIT UNTIL YOUR NEXT SCHEDULED APPOINTMENT PLEASE CONTACT:

CRISIS INTERVENTION AT 717-763-2222 (24-HOUR CRISIS)

OR CALL 911 AND ASK FOR A MENTAL HEALTH DELEGATE.

Dr. Lee Morand & Associates, LLC
411 E. Main St.
Mechanicsburg, PA 17055
717-610-2988

OPTIONAL

PLEASE COMPLETE THE INFORMATION BELOW IF YOU WOULD LIKE YOUR CREDIT CARD CHARGED FOR PAYMENTS AT THE TIME OF YOUR DATE OF SERVICE:

Client Name:

_____

Name on Credit Card (if different than above):

_____

_____

Credit Card Number:

_____

Expiration Date:

_____

Security Number (on back of card):

_____

Billing Zip Code:

_____

Receipt

Email:

_____
__

or

Text:

_____
___

or

No Receipt: _____

Please notify your therapist or the office manager if you have any changes to the information you provided.