SAN TAN COUNSELING

THANK YOU FOR YOUR COOPERATION BY PROVIDING US WITH ACCURATE INFORMATION, WE CAN SERVE YOU BETTER AND MORE EFFICIENTLY.

PATIENT INFORMATION

Date: _____ **Referred by:** _____

Name: _____ **SS#:** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____ **Email:** _____

Mailing Address, if different: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **May We Leave a Message?** ❑ Yes ❑ No

DOB: _____ **Age** _____ **Gender:** ❑ Male ❑ Female ❑ Non-Bianary

Preferred Pronouns: ❑ He/Him ❑ She/Her ❑ They/Their

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Other Household Members:

Relationship	First Name	Last Name	Gender	Birth Date
_____	_____	_____	❑ M ❑ F	_____
_____	_____	_____	❑ M ❑ F	_____
_____	_____	_____	❑ M ❑ F	_____
_____	_____	_____	❑ M ❑ F	_____
_____	_____	_____	❑ M ❑ F	_____

Employment Status: (Check all that apply) ❑ Employed Part-time ❑ Employed Full-time ❑ Unemployed ❑ Retired ❑ Part-time Student ❑ Full-time Student

Employer or School: _____

Work Phone: _____ **Can you be located at this number?** ❑ Yes ❑ No

IN CASE OF EMERGENCY

Contact Name: _____ **Phone number:** _____

Relationship: _____

PARTY RESPONSIBLE FOR PAYMENT

Relationship: ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ **Date of Birth** _____ **SS#:** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____

Employer's Address _____ **City** _____ **State** _____ **Zip** _____

San Tan
Counseling, PLC

480.982.2356

3740 E. Southern Ave, Ste 120 Mesa, AZ 85206

FINANCIAL POLICY

You are responsible to know your insurance contract for benefits and for all visits in our office. If your insurance requires a SPECIAL CLAIM FORM, we must have it WITHIN 2 WORKING days or the INSURANCE BILLING will be processed and sent without it. Insurance is usually not designed to pay the entire fee. **Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the Patient Responsibility of the bill as contracted with your insurance company for each session (unless otherwise restricted by law or agreement we might have with your insurer).**

Patients without insurance will be on a cash pay basis. Charge Masters $100.00 / PhD $120.00

ALL CO-PAY AND CASH VISITS ARE TO BE PAID AT TIME OF VISIT.

If you must cancel or reschedule your appointment, please give us 24-hour notice. Failure to give us advanced notice will result in a **charge of $ 65.00,** except in emergency situations (if this happens, please discuss it with your therapist as soon as possible).

If your insurance company rejects your claim, policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full, contact our business office.

RETURNED CHECKS: A $25.00 handling charge is applied to all returned checks.

I have read and agree with the Financial Policy of this office.

_____

Patient/Guardian Signature (if patient is under 18 yrs of age) **Date**

San Tan Counseling, PLC

NOTICE OF PRIVACY PRACTICES

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

PAYMENT: We use and disclose your PHI to your insurance company in order to receive payment for your covered health expenses.

Victims of Abuse, Neglect or Domestic Violence. We may disclose PHI to government agencies about suspected abuse, neglect or domestic violence.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, effective with the date of the letter of revocation.

HEALTH CARE: We may use and disclose PHI to other health care providers (physicians, healthcare professionals, laboratories or hospitals) to better assist in your diagnosis and treatment.

MEDICAL RECORDS REQUEST: We will disclose your PHI if we receive a request from another physician who is treating you or will be treating you with a signed request from you. We will disclose your PHI to an insurance company if we have filed a claim on your behalf.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding protected health information that our office maintains about you.

RIGHT TO ACCESS YOUR PROTECTED HEALTH INFORMATION. You have the right to review or obtain copies of your PHI records. Your request to review and/or obtain a copy of your PHI records must be made in writing. We may charge a fee for the costs of producing, copying, mailing your requested information, but we will tell you the cost in advance.

FOR INFORMATION REGARDING EXERCISING YOUR RIGHTS You may exercise any of the rights described above by contacting our Office Manager. See the end of this Notice for the contact information.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing and sent to the Office Manager listed at the end of this Notice. We support your right to protect the privacy of your PHI. We will not retaliate against you or penalize your for filing a complaint.

CONTACT SAN TAN COUNSELING If you have any questions or complaints about this Notice or you want to submit a written request to our office in any of the previous section of the Notice, please call (480) 982-2356 or write to us at:

San Tan Counseling
Attn: Office Manager
3740 E. Southern Ave, Ste 120
Mesa, AZ 85206
Day number and message number 24 hours a day (480) 982-2356

Get full copy of San Tan Counseling's privacy notice at the office.

_____ _____

Patient/Guardian Signature (if patient is under 18 yrs of age) **Date**