The following pages are intended for use by our clients (new & existing) only. They are copyrighted and must not be used for any other purpose than that associated with visits for treatment with Dr. Feinsilber.
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Affiliated Psychological Services, PC
Mark P. Feinsilber, Ph.D.

Patient Background Information

Today's date ________________

Personal Information

Client's full name ____

Social Security # ____

Parent's Name (if client is under 18 years) ___________________________________

Home Phone No. ____
Cell Phone No. ____
Work Phone No. ____

Home Address: ____

________________________ City ________________ State ________ Zip _________

Email address (optional) ____

Date of Birth (client's) ____
Age (client's) ______________

School Information (if applicable)
Name of School ____
Address ____
Tel # ____
Contact Person ____
Grade ____

Attorney's name (if applicable) ____
Attorney's address ____
City ____________________ State _____ Zip ___________
Attorney's Tel # ____

Insurance Information (please fill out carefully)

Name **of Insured** ________________________________ SS # ____________
Address **of Insured** ____
City __________________ State ________ Zip _____________
Employer (**of Insured**)____
Work Phone # ____

Name of Insurance Company (as written on your insurance card) __________________

____

Member Services Phone No. (as written on your insurance card) ___________________

Member ID. # / Policy # (as written on your insurance card) ____________________
Group # (as written on your insurance card) _________________________________

Referred by (if applicable) ____

Clinical Information (of then client)

Please describe any current symptoms – both physical and/or emotional – in detail :

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Medication and Physician Information (of client)

Current Medications (please include dosages) ________________________________
____
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____

Primary Care Physican

Name ________________________________
Address ________________________________
Tel # ________________________________

Other **Specialist** (s) ________________________________

In case of emergency

Who should we contact? ________________________________
Address ________________________________
Phone # ________________________________

Relationship to you (client) ________________________________

Please do not forget to sign!

Your **signature** here ________________________________
(Patient Signature – Parents if under 18 years of age)

Affiliated Psychological Services, PC
Mark P. Feinsilber, Ph.D.

Fee Schedule as of January 1, 2005

Service Description	Session
Initial Intake	$ 150.00
Family or Couples Sessions	$ 150.00
Individual Sessions	$ 125.00

(Note: sessions are based on a 45-minute hour)

Payment: the client will be expected to pay for each session at the time services are rendered. If the client belongs to an HMO/PPO/POS entity with which APS is affiliated, the client may be required to make a co-payment at each visit, the amount of which is determined by the client's contract with his/her insurance company. This co-payment can be predetermined for the client upon the client's furnishing APS' Office Manager with relevant information (ID card, authorization # etc.).

As a courtesy, APS will file for insurance reimbursement as well as verify client's benefit payment. However, the client will be ultimately responsible for the payment of any professional fees, regardless of the client's insurance coverage at the time of service, in the event that either the client's insurance company or any other client's provider organization, allied with the client's carrier, denies APS' claim or is delinquent with reimbursements to APS. (As part of APS' verification process with all insurance companies APS is provided up front with a disclaimer by the insurance companies, stating that the information provided "is not a guarantee of payment").

It is official APS Office Policy that the client will be billed whenever the client's existing account exceeds a running balance of $100.00 at which time the client will be asked to bring his/her account current. In the event that APS subsequently receives surplus insurance reimbursements, these will then be refunded promptly to the client.

Checks, which are written to us by clients, which are returned by the client's bank for any reason, will require the client to pay APS immediately for that amount, either in cash, money order or cashier's check. A returned check surcharge of $50 will be added to this amount and is payable in full.

Pre-scheduled telephone sessions or other impromptu calls that exceed five minutes are charged at the rate of $125.00 per hour (time prorated in fractions of that hour). Please be aware that this includes also times the client may choose to page Dr. Feinsilber with a clinical emergency,

Services provided outside the APS facilities (Norcross or Cumming), i.e. court appearances, agency or school consults etc., are billed at a rate of $150.00 per hour, plus travel time (2 hours minimum).

If psychological testing is performed, there are individual charges for each test administered, which the client is responsible for. These charges are to be paid in full at the time of administration of testing. Testing fees include full VERBAL feedback. However, if the client requires a formal WRITTEN report, this report will be billed separately and is usually not covered by the client's insurance company. Please be advised that no testing results or interpretations of any tests will be provided to the client, until all testing fees have been paid in full, including report charges, is a report is to be handed over to the client in writing. Testing benefits through the client's insurance company, if any exist, can be predetermined for the client by our Office Manager prior to these services being rendered. In these cases, the client's fee responsibilities may be diminished.

Cancellations/Unkept Appointments/Lateness: Unkept appointments or appointments, which are not cancelled at least 24 hours prior to the appointment time, will be charged for. APS has a 24-hours, 7-days-a-week voice mail coverage as well as pager coverage for emergency calls and cancellations. Unforeseen ***legitimate*** emergencies (sudden serious illness, accidents, family deaths,) which occur less than 24 hours prior to the appointment time, which require the client to cancel his/her appointment, are usually negotiable in terms of fees incurred.

Please do not forget to sign below

I, the client, accept responsibility for all fess incurred and agree that if it is necessary for APS to pursue collection activity on my account, either through a collection agency or an attorney, I, the client, shall be responsible for all costs of such collection activity, including, but not limited to, reasonable attorney's fees. Collection fees of 30% (thirty percent) will be added to the client's account balance to cover such service fees.

I, the client, hereby acknowledge that I have **read and understood** the foregoing APS office policies and agree to abide by them.

______________________________ ________________

(**signature of client** – must be at least 18 years old) date

____

(**signature of Responsible Party**, if other than client)

Managed Care, you – the client – and your treatment

I, Dr. Feinsilber, have agreed to see you, the client, under the terms set by the Managed Care Company, which oversees your (the client's) mental health benefits. In order to avoid misunderstandings regarding what this means, I am outlining some of the general aspects of **Managed Care** below.

Managed Care means that an outside company has been engaged to select approved therapists and to determine both your need for treatment and the length of time that treatment will be provided for. If I am working with you (the client) as a managed care patient, I have entered into a contract with the ***Managed Care Company***. While the contracts may vary somewhat, you (the client) should be aware of the following, which applies to ALL cases:

The ***Managed Care Company*** will receive regular and somewhat detailed reports regarding your (the client's) symptoms, diagnosis and treatment. There are no restrictions on the type or amount of information that the ***Managed Care Company*** may require from me. I will be glad to discuss the content of these reports with you, the client. While my experience is that the information provided has been treated with an appropriate degree of confidentiality, I cannot be responsible in any way for the ***Managed Care Company's*** use or disclosure of the information provided to them.

In many instances, the ***Managed Care Company*** must approve all sessions in advance. Each ***Managed Care Company*** has its own criteria regarding what it will consider as a 'medical necessity' for therapy. Therapy sessions beyond what is determined medically necessary by the ***Managed Care Company*** must be paid for by you, the client, directly, should you, the client, and I agree to continue to meet after the number of authorized sessions has expired.

I will be glad to answer any questions you, the client, may have about this. Please sign the statement, indicating that you have been advised of this information. A copy of this page will be provided to you, the client, upon your request.

Please do not forget to sign!

__________________________________ ____________________
(signature of client – must be 18 years old) date

____
(signature of Responsible Party)

Affiliated Psychological Services, PC
Dr. Mark Feinsilber
6030 Bethelview Road, Suite 401, Cumming, GA 30040

Financial Policy

Patient Name: ………………………………….. SS # ………………

We are committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank may result in a $25 returned check charge being added to your account.

2. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.

3. It is your responsibility to contact your insurance carrier to confirm that our psychologist participates on your plan. If you see a doctor, who is not currently on your plan, you will be responsible for payment in full.

4. If your plan requires a referral, it is your responsibility to obtain this referral prior to being seen by the doctor. If we are required to obtain the referral for you, please notify our office 72 hours prior to the specialist visit so that we have ample time to acquire this information from your insurance company.

5. All co-payments are due at the time of service, no exceptions.

6. If you miss your appointment, you will be charged a **NO-SHOW** fee of **$ 75** for each appointment missed, **no exceptions**.

7. All record requests must be in writing and received by our office at least 72 hours prior to the date needed. Records over 10 pages will only be mailed, not faxed. All mental health records requests will have a FEE based on the number of pages. The usual range of fees for this service is from $ 10 to $ 50. Occasionally, the fee could be over $50 if there are excessive pages to copy.

8. **Our office collects an *optional* Administrative Services Fee of $ 5 on *each* visit. This Administrative Fee is intended to cover the cost of certain Administrative Services we may have to provide, which are not covered by your insurance.**

9. **You are not required to pay the Administrative Services Fee; however, if you choose not to pay the *optional* Administrative Services Fee, you will be charged for all non-covered Administrative Services, as needed. A list of our Administrative Services with associated fees is attached to this Financial Policy.**

{ } I accept the **Financial Policy**, which includes payment of the **Administration Services Fee**.

{ } I accept the **Financial Policy**, but choose **not to pay** the **Administration Services Fee**. I understand the services listed, on the next page, are included in the **Administration Services Fee (ASF**). I understand that, if I elect not to pay the **ASF**, I will pay out of pocket for these services, as I need them, at the fee schedule listed.

(*please mark your choice clearly by initializing the appropriate box above*)

……………………………………………. ……………………

(Patient Signature or parents/legal guardian if patient is under the age of 18 years) (date)

Affiliated Psychological Services, PC

Dr. Mark Feinsilber

Norcross/Cumming Offices

Adminstrative Services

Chargeable items you will pay for on an 'as requested' basis. This list includes, but is not limited to:

1. Completion of all forms (to include but not limited to) **$ 75/ form**
   - FMLA
   - Disability, long or short term
   - Worker's compensation
   - Life Insurance
   - Board of Education forms
   - legal and court related forms
   - other miscellaneous – our administrative forms required by third parties other than your insurance company

2. Patient requested, computer generated reports (extra claims, statements, payment histories, etc.) **$ 5/ request**

If you have a request, which we can perform other than administrative services, which are also non-covered services under your certificate of insurance, we will generate a charge for these additional, non-covered services. We will notify you and your insurance company of these additional charges associated with the service requested. It is your responsibility to request and pay for such services.

Thank you for your continued support of our practice.