New Day Psychology, LLC
Vered Dor Psy.D

PATIENT INFORMATION

Last Name______________________ First__________________ MI_____ Marital Status_____
Street Address___________________________ City ______________ State_______ Zip_______
Cell Phone_________________________ leave message? Yes ☐ No ☐
Home Phone________________________ leave message? Yes ☐ No ☐
Date of Birth__________________ Age____ Gender______ Soc.Sec.Num______________________
Email Address_______________________________ Referred By____________________________
Employer___________________________________ Work Phone____________________________

GUARANTOR INFORMATION

Last Name______________________ First__________________ MI_____ Marital Status_____
Street Address___________________________ City ______________ State_______ Zip_______
Cell Phone_________________________ leave message? Yes ☐ No ☐
Home Phone________________________ leave message? Yes ☐ No ☐
Date of Birth__________________ Age____ Gender______ Soc.Sec.Num______________________
Email Address_______________________________ Referred By____________________________
Employer___________________________________ Work Phone____________________________

POLICY HOLDER INFORMATION

Last Name______________________ First__________________ MI_____ Marital Status_____
Street Address___________________________ City ______________ State_______ Zip_______
Cell Phone_________________________ leave message? Yes ☐ No ☐
Home Phone________________________ leave message? Yes ☐ No ☐
Date of Birth__________________ Age____ Gender______ Soc.Sec.Num______________________
Email Address_______________________________ Referred By____________________________
Employer___________________________________ Work Phone____________________________

	PRIMARY	SECONDARY	OTHER
INSURANCE NAME			
POLICY HOLDER NAME			
POLICY NUMBER			

RELATIONSHIP TO PATIENT: ____

All signatures contained herein apply to services rendered at:

NEW DAY PSYCHOLOGY, LLC

14333 Beach Blvd. suite 33 Jacksonville FL. 32250
*Phone: 847-980-8707. *Fax: 847-282-1650
* E-Mail: dr.vdor@gmail.com * Website: www.newdaypsy.com

Informed Consent for Treatment:

I hereby agree and consent to participate in treatment/testing services provided by my provider. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature_____________________________________**Date**____________________

Relationship to patient (if applicable) ____

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services: (Billing)

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third-party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient Name___________________________________ **Date**______________________

Patient OR Guarantor Signature (if patient is a minor) ________________________

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Medicare Authorization and Assignment of Benefits:

I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature________________________________Date___________________________

HIPAA Privacy Notice Acknowledgement:

I understand that I have been given an opportunity to read a copy of my provider's Notice of Privacy Practices. I understand that if I have any questions, that I can direct my question to my provider of service.

Signature________________________________Date___________________________

Confidentiality

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian.

Limits of Confidentiality:

Notified exceptions to the confidentiality agreement are as follows

Duty to Warn and Protect- When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults- If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances- Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

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Minors/Guardianship- Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Name____

Signature ______________________________ **Date:** ______________

Client's Parent/Guardian (if under 18) __________________**Today's Date**_________

Cancellation and No-Show Policy

My signature below shows that I understand and agree to comply with the cancellation/no-show policy. I understand that there is a $ 150 fee if I do not show up for an appointment and do not call. I also understand that there is a $50 fee if I call to cancel with less than 24 hours' notice. Thank you for your consideration regarding this important matter.

Client's Name________________________________ **Date**______________

Client Signature (Client's Parent/Guardian if under 18) ______________**Date**________

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