Psych Associates of Maryland, LLC

PATIENT INFORMATION UPDATE

Patient Name: _____ Birthdate:____/_____/____

If you have **new information** that you have not yet shared with us, please complete the appropriate sections below:

Change of address to: _____

_____

New telephone: _____ (home/work/cell)

Emergency contact:_____

Insurance change to: _____ Effective date:_____/____/____

Policy #:_____ Group#: _____ Employer:_____

Policyholder Name:_____SS#:_____Birthdate____/____/____

Relationship to Patient: Self Spouse Parent Other

Other changes to my account information:_____

ALL PATIENTS, PLEASE READ CAREFULLY AND SIGN BELOW:

I acknowledge that, while my care will not be affected, my doctor and/or therapist are now providing services under Psych Associates of MD, LLC. All medical records will transfer to the new organization, and any permission I previously gave for release of information will also transfer to the new organization unless I specifically revoke it in writing.

I understand that I am responsible for my entire fee. I authorize Psych Associates of Maryland, L.L.C. to bill my insurance company directly and receive compensations for services rendered. Since some insurance companies require precertification, I will call my insurance company to inform them of my choice to utilize services from Psych Associates of Maryland, L.L.C. **Payment is expected at the time of service. In the event that my account becomes delinquent and is forwarded to an attorney for collection, I am responsible for the attorney fees and all court costs. Additionally, I will be responsible for full payment of the missed appointment fee when 24 hours' notice is NOT given for cancellation.** I also authorized Psych Associates of Maryland, L.L.C. to send treatment plans to my insurance company in order to obtain future authorizations. I understand that Psych Associates of Maryland, L.L.C. is an independent practitioners' group. I give my full consent to the Physicians, Psychologists, Social Workers and Psychotherapists within the group to exchange information to facilitate treatment. I understand that I can revoke this consent at any time with a written notice.

_____ _____

Signature of the patient or individual responsible for payment Date