Hanna Psychological Services

444 N. Northwest Hwy., Ste. 375
Park Ridge, IL 60068
(P) 224-585-3325 || (F) 224-585-0191
http://hannapsych.com

REGISTRATION FORM

Today's Date:

Patient Name: Date of Birth:

Street address:

City, State: Zip:

Home Phone: Cell Phone:

Email:

For Couples or Minors (under age of 18)

Partner/Guardian Name: Email:

Home Phone: Cell Phone:

Parent/Guardian Name: Email:

Home Phone: Cell Phone:

Emergency Contact Information

In case of an emergency, notify:

Relationship: Phone:
(This will only be used in case of medical emergencies, not to share confidential information)

Referral

Whom/what service may I thank for referring you to me?

At Hanna Psychological Services, PC (HPS), it is important that you are informed about all aspects of your care, and that includes cost. Below you will find a disclosure of the most common fees to expect. These are fees charged for individuals paying without the use of insurance or submitting to insurance for out-of-network reimbursement. My in-network rates are determined by my contract with the insurance company, which I am happy to share upon your request. Please ask about any fees not posted here or on the HPS website (http://hannapsych.com). In case of separation or divorce, the parent bringing their child for treatment is responsible to pay for the services provided unless otherwise agreed upon prior to treatment.

It is the patient's responsibility to determine if HPS is an in-network provider with his or her insurance company. If you would like assistance making this determination, please feel free to ask. HPS will submit claims on the patient's behalf for both in-network and out-of-network claims. In order to prevent unexpectedly large balances, I strongly recommend patients find out whether they need to fulfill a deductible amount before other benefits begin.

Disclosure of Fees

Initial Evaluation (1st appointment): $160*
Individual therapy: $140* (45-55 minutes); $150* (55-65 minutes)
Family or Couple's therapy: $150* (50-60 minutes)
Phone Calls: $130/hr* for calls longer than 15 minutes
Missed appointments or cancellations within 24 hours: Out of pocket fee for your scheduled type of session – cancellations are not billable to insurance
*Sliding scale fees are available for up to 20% of Dr. Hanna's caseload.

Billing Information: Insurance

Policy Holder: _____ DOB: _____

Employer: _____

Name of Insurance Company: _____

Policy/ID#: _____ Group #: _____

Phone number of Insurance Company on card: _____

If known, deductible: _____ Copay: _____

Billing Information: Non-Insurance Payment

Person responsible for paying balances: _____

Address (If different from above): _____

Patients who have an outstanding balance will be billed monthly, and the balance is due 30 days from the billing date. In circumstances where the account balance has not been paid within 60 days from the date that services were provided, your credit card that is on file will be charged the full outstanding balance. If the credit card provided below is not approved for the full outstanding balance, your account may be referred to an independent collection agency and any necessary information for the purpose of collecting the fees will be included. Any costs incurred in the collection process will be added to the original balance. Once the account is paid in full or an agreed upon payment arrangement has been made with HPS, the patient will be eligible to continue to receive services at HPS.

HPS also accepts checks and cash in the exact amount. Please make personal checks payable to Hanna Psychological Services, PC. Please note that a $40.00 fee will be charged for any returned checks.

Please provide credit card information to be kept on file. This information will only be used in accordance with the policy above. If you consistently pay your balance by another means, your card information will be kept in a locked location.

Credit Card #:

Expiration Date: 3 Digit Security Code:

Patient Name: Card Member's Name:

Card Member's Billing Address:

Card Member's Signature: _____ Date:

Would you like balances automatically charged to your card? Yes ☐ No ☐

I, the undersigned, have read, clearly understand and agree to abide by the financial policy. I authorize the release of any personal or health information required to process my claims. My signature also authorizes payments of my benefits from my insurance company to Hanna Psychological Services, PC directly for the services rendered. I understand, and guarantee, that I am responsible for any charges not covered by my group or individual insurance plan/s. I also understand any professional fee listed above is subject to change.

Signature: _____ Date:

Witness (Therapist): _____

Communication Preferences

I consent to have Hanna Psychological Services contact me in the following ways:

Voicemail
HPS may leave me a voicemail at the following numbers:

☐ Home ☐ Cell

Written communication
HPS may communicate with me in writing in the following ways:

Scheduling/ Appt. Reminders:		☐ Text message	☐ Email	☐ Secure messaging
Billing:	☐ Postal mail	☐ Text message	☐ Email	☐ Secure messaging
Therapeutic support:		☐ Text message	☐ Email	☐ Secure messaging

Consent

I acknowledge that I have read, understand and agree to the information provided in the Informed Consent and HIPAA policies, and that I have had my questions answered thoroughly. I do hereby seek and consent to take part in psychotherapy with Dr. Hanna at Hanna Psychological Services. I am aware that I may terminate psychotherapy at any time.

Patient Signature Date

Partner/Parent/Guardian Signature Date

Provider's Signature Date