1502 West NC Hwy 54, Suite 603
Durham, NC 27707
919-419-3110 x115

Mark Scalco, Ph.D.
Licensed Psychologist

4601 Lake Boone Trail, Suite 2C
Raleigh, NC 27607
919-419-3110 x115

# Client Registration Information

--Confidential--
Please fill out all information

Today's Date: _____

How did you hear about us? _____

Client's Last Name: _____

First Name/Middle Initial: _____

Date of Birth: _____

Address: _____

_____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

## Employment/School Information

Employer: _____

Occupation: _____

School: _____

Grade/Year: _____

## Individual Responsible for Bill
(if different from client)

Name: _____

Relationship to Client: _____

Address: _____

I hereby certify that I am responsible for all debt assumed by the above named "Client" for the treatment rendered by Mark Scalco, Ph.D.

Signature: _____

Date: _____

## Medical and Health Information

Primary Care Physician: _____

Date of Last Physician Visit: _____

Previous Psychotherapy?: Y N When?:_____

Name of Last Therapist: _____

# Client Registration Information



WILL YOU BE USING HEALTH INSURANCE? Yes _____ No _____

DO YOU WANT US TO BILL YOUR INSURANCE FOR YOU? Yes _____ No _____

If you answered "No" to either question, please skip to page 3

## Insurance Information

Name of Policy Holder (if different from client):

_____

Policy Holder's Address (if different from client):

_____

_____

Policy Holder's ID #: _____

Policy Holder's ID#: _____

Authorization # (if applicable): _____

Insurance Company: _____

Address: _____

_____

_____

Phone: _____

Policy Group #: _____

Policy Holder's Employer: _____

Co-payment Amount: _____

## Signature Releases for Insurance and Payment

I authorize release of information to my insurance carrier and/or agents as required for payment of claims and/or insurance business operations.

I authorize all claims to be sent directly to my insurance company, electronically if necessary.

I authorize the payment of insurance benefits to be made directly to my provider/therapist for services provided.

I agree to be responsible for any unpaid balance resulting from denial of claims by my insurance carrier.

Signature: _____ Date: _____

# Client Registration Information



## TREATMENT CONSENT

This form is to document that I/we, _____,
Name of client OR Name of guardian if client is a minor OR Names if members of a couple
give permission and consent to Mark Scalco, Ph.D. to provide psychotherapeutic assessment and treatment to me/us and/or _____, who is my child.
Name of client if a minor

While I expect benefits from this treatment, I fully understand that because of factors beyond our control such benefits and particular outcomes cannot be guaranteed.

I have read and understand the Policies and Procedures of Mark Scalco. I have also read and understand the "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information" (HIPAA and business policies are available on-line at *http://hopevalleypsych.com/scalco.htm*). I will ask questions about any policies that I do not understand.

I understand that I am financially responsible for my treatment or any portion of fees that is not covered or reimbursed by my insurance. I also understand that I will be charged a cancellation fee for any appointment not cancelled within 24 hours prior to the session. Insurance companies do not reimburse for this late fee.

I know of no reasons I/he/she/we should not undertake this therapy/assessment and I/he/she/we agree to participate fully and voluntarily. I understand that I may terminate treatment at any time.

Signature 1: _____ Date: _____
(of client or custodial parent if client is a minor)

Signature 2: _____ Date:_____
(of second client if member of a couple)