

Lake Boone Counseling &
Psychological Services, LLP
3921 Sunset Ridge Rd., Suite 307
Raleigh, NC 27607
919-782-2933 x115

Mark Scalco, Ph.D.
Licensed Psychologist

Hope Valley Psychotherapy
Associates, LLP
1502 NC Highway 54 W., Suite 603
Durham, NC 27707
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: _____ Social Security Number: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Employers' Address: _____

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? _____ When? _____ Therapist Name: _____

Client Registration Information

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WILL YOU BE USING HEALTH INSURANCE?

Yes _____ No _____

DO YOU WANT US TO BILL INSURANCE FOR YOU?

Yes _____ No _____

If you answered "No" to either question, skip next 2 sections.

INSURANCE INFORMATION

Name of Policy Holder (if different from client):

Insurance Company: _____

Address: _____

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

Phone: _____

Policy Holder's ID #: _____

Policy Group #: _____

Policy Holder's Date of Birth: _____

Policy Holder's Employer: _____

Authorization Number: _____

Co-payment Amount: _____

SIGNATURE RELEASES

A) I authorize release of medical information to my insurance carrier and/or agents as required for payment of claims.

Signature: _____ Date: _____

B) I authorize all claims to be sent directly to the insurance company, electronically if necessary.

Signature: _____ Date: _____

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

Signature: _____ Date: _____

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

Signature: _____ Date: _____

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TREATMENT CONSENT

This form is to document that I/we, _____, transfer permission and consent to Mark Scalco, Ph.D. to provide psychotherapeutic assessment and treatment to me/us and/or _____, who is/are my/our child/children.

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."

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

Date: _____

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

Date: _____