

**Donald E. Sloat, Ph.D.**

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**Psychology**

**IDENTIFYING INFORMATION**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse \_\_\_\_\_ SSN \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone \_\_\_\_\_

Pager \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Website \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person financially responsible for this account \_\_\_\_\_

Insurance Company \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Plan Name \_\_\_\_\_

SSN or Contract Number \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I will be paying by: Cash \_\_\_\_\_ Check \_\_\_\_\_

**(Please continue reading on the other side)**

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**Welcome !** I am pleased that you have selected my office for your psychological services. I intend to do everything I can to help you reach your goals. As we work together, there are several important items of information that I want you to keep in mind.

**Confidentiality**—Under normal circumstances all information you give me is confidential by law and will not be disclosed to anyone without your consent. There are exceptions to confidentiality under certain conditions. When a person's life or well-being is in danger, whether it is the person seeking therapy or another individual, the doctor is responsible to protect life even if it violates confidentiality. If you have any questions about confidentiality, especially as it relates to children and adolescents, please ask me. Your signature on this form gives consent that (1) information necessary to process your claim may be provided to the insurance company, and (2) the insurance company may send payment to this office. I typically send them as little information as possible.

**Insurance**—I accept most insurances. If you belong to an HMO, your benefits may not cover your sessions at my office without certification from the HMO. Be sure to discuss it before your first session. If you have insurance coverage, the contract is between the policyholder and the insurance company. I will bill your insurance carrier for services rendered, documenting your diagnosis, types of services provided, dates of service, and provider name. However, your insurance carrier may decide not to pay the charges for several reasons: 1) You have not met your deductible; 2) The service is not a "covered service." 3) The carrier may deem the service covered, but not "medically necessary" in this specific situation. If your insurance carrier does not pay for the sessions, you will be liable for the full charge on a private pay basis.

**Charges**--The charge for each full consultation (the standard therapy hour is 45-50 minutes) is \$110.00. HMO and Medicare rates vary. If psychological testing is necessary, the charge is in addition to the consultation fee. If you must cancel an appointment, please call at least 24 hours in advance to avoid a late cancellation charge. Charges for late cancellations and "no shows" will be listed as "late cancellations" and "no shows" on the statement. Since insurance does not pay for these charges, you will be responsible for the entire amount. A \$10.00 fee will be charged for returned checks.

**Payment**—You may choose from one of two payment plans, cash or check. Payment is expected before each session unless you request other arrangements. It is your responsibility to submit your insurance claim forms unless your policy requires me to submit it or we agree otherwise. I will provide the required billing statement for the insurance company. When insurance checks are sent to the policyholder, please bring the insurance company's worksheets to the office so I can credit payment to the correct dates.

**Unpaid Balances**—If an account remains unpaid after sixty days and the person responsible for payment has been notified without responding, the account will be transferred to formal collection procedures. If you have a time payment plan, you may not have a balance over \$300.00.

**Consent**—I have read the above information and understand it. Any questions I have about this information have been answered. I consent to enter therapy knowing that the results cannot be guaranteed.

**Questions**—If you have any questions about billing or insurance procedures, please feel free to discuss them with me at any time. I am happy to discuss any questions.

\_\_\_\_\_  
Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Parent or guardian if patient is a minor

Date \_\_\_\_\_