Dana Group Associates

220 Reservoir Street, Suite 21
Needham, MA 02492-2502

781-449-1143
Fax: 781-449-5992

FOR DGA INTERNAL USE: **MEDfx #** **SYSTEM DATE**

Client Registration Form

Client Information **Date of 1ST Appointment:**

Name _____ Date of Birth _____
Soc Sec # _____ Sex M - F Age _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____
Occupation _____ Employer _____
Email _____

Responsible Party For All Payments Due for Client Services

Name _____ Relationship to Client _____
(If different than above)
Marital Status: _____ Child Custodial Status _____
Address _____
Telephone(s) _____
Signature _____

Home Contact Information

Name _____ Phone _____
Address: _____ Cell Phone _____

Emergency Information

Contact Name _____ Phone _____
Specifics _____

Referred by _____ **Primary Care Physician** _____

Family Members/Others Living in Home

Name	Relationship to Client	Date of Birth	Occupation/School

Insurance Information: Copy of both sides of Client's Insurance Card Required-
Subscribers Full Name: _____ **DOB:** _____

FOR DGA INTERNAL USE

Clinician _____ CPT Code: 90801 Initial Intake Date _____

Diagnosis at Intake
Axis I _____ _____
Axis II _____ _____
Axis III _____ _____
Axis IV _____ _____
Axis V _____ _____

PLEASE FILL OUT BOTH SIDES OF SHEET

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www.dana-group.com

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

SIGNATURE PAGE

This form is an agreement between you _____ and Dana Group Associates. When we use the word "you" below it will mean your child, relative, or other person if you have written his name here.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing that you have read and understand our Notice of Privacy Policies and you are agreeing to let us use your information here and send it to others in accordance with our written policies. Please make sure you have read and understand our Privacy Policies above before signing this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Policies, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Policies. If we do change it, you can get a copy from our website: www.dana-group.com or by calling us at 781-449-1143 x300.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____	_____
Signature of client or personal representative	Printed name of client or personal representative
_____	_____
Date of Signature	Date DGA received by client or representative

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October 30, 2012

Dear Dana Group Clients,

As of November 1, 2012 we will be implementing a new financial policy that **requires** all clients to have a **credit card** on file. Please check with your clinician about the change in policy and the need for your signature on these forms. For existing clients, all past unpaid billing charges will need to be paid through this agreement prior to additional services being rendered.

Thank you,

Dr Robert C Maron

Dr. Robert C. Maron
Director
Dana Group Associates

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Credit Card Authorization

We require a credit card authorization on file for every client. In the event that you cannot or do not pay for whatever fees are your responsibility at the time of your visit, we will submit the charge to your credit card. Your signature below indicates your agreement and consent to this process. Your card will be charged only if you do not pay at the time of your visit, or if there are outstanding charges for deductibles, co-payments, missed appointments, late cancellations, or service charges.

I, _____, authorize
(please print your name as it appears on your credit card)

Dana Group Associates to submit charges for professional services provided for

_____
(name of client)

to my credit card. This authorization will be in effect until I notify Dana Group Associates in writing to discontinue this authorization. This authorization applies to all legitimate charges for any individual for whom I have accepted financial responsibility, and includes all currently outstanding charges and future charges.

_____ _____
Card Type Visa/MasterCard Card Number

_____ _____
Expiration Date Name of Card Holder, Printed

_____ _____
V-Code Signature of Card Holder

_____
Date of Signature

FOR OFFICE USE ONLY

CLINICIAN(S) _____

_____**GROUP** _____**INDIVIDUAL MedFX #**_____

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FINANCIAL POLICIES AGREEMENT

Payment for services provided by Dana Group Associates is due at the time services are rendered unless payment by health insurance has been arranged prior to the visit. If insurance coverage has been arranged, payment of any applicable copayment or deductible is due at the time services are rendered. If we do not have a contractual provider relationship with your insurance plan, full payment for services is due at the time services are provided. We will bill your insurance for you, and reimburse you if we receive payment. You agree to be fully responsible for payment for all services not covered by your insurance. I there is a problem with your insurance coverage, you agree to pay your bill and deal with your insurance company yourself. As a courtesy to you, we will attempt to verify your insurance coverage and determine and determine your insurance benefits. However, if your insurance company has misinformed us or you feel we have misinformed or failed to adequately inform you regarding your benefits, you are still responsible for payment of all charges not covered by your insurance. We encourage you to verify your insurance benefits and coverage yourself and make sure that you fully understand your coverage. By signing this agreement you agree to responsible for all charges for the client identified below, even if you believe that some other party should bear responsibility for these charges. **Some services may not be covered by health insurance.** You agree to be fully responsible for payment for all services that are not covered by the health insurance plan. This may include charges for telephone consultation, written correspondence, or reports in connection with a client's evaluation or treatment, including consultation or correspondence with the client, family members, past or current treatment providers, educational professionals attorneys, courts, agencies, or others. Limited telephone consultation is part of routine patient care and is undertaken without charge. However, when extensive telephone consultation or other than routine written correspondence or reports are requested or required, a charge for these services will be applied. If these charges are excluded from coverage by health insurance plan, they will be your responsibility. Every effort will be made to notify you if such charge is likely to occur. However, the exact amount charged cannot always be predicted in advance.

When an appointment is missed or canceled without at least 24 hour prior notification a $100 fee for the cancelled appoint will be charged. Fees charged for missed appointments or late cancellations must be paid prior to the next appointment. A service charge of 1.5 % of the outstanding balance or a minimum of $5.00 will be added each 30 day billing cycle to all outstanding balances over 60 days past due. A charge of $25.00 will be applied for all checks returned unpaid. If an overdue account is sent to a collection agency, collection fees and expenses will be added to the amount due. A copy of the current applicable fee schedule of Dana Group Associates is available upon request. Fees may be modified without notice.

ACKNOWLEDGEMENT AND AGREEMENT

I have read the above and affirm that everything in this form that was not clear to me has been explained to my satisfaction. I understand that it is my responsibility to know my insurance benefits. I hereby agree to abide by the policies specified above and to be responsible for all fees and charges for services provided by Dana Group Associates to or on behalf of the client named below. This agreement will continue as long as Dana Group Associates provides services or until written request that this agreement be terminated is received by Dana Group Associates.

Assignment of Health Insurance Benefits: This signature below authorizes payment directly to Dana Group Associates of benefits under health insurance policy covering the client named below. A photo copy of this form is considered as valid as the original. For Medicare Clients only: The undersigned hereby requests that payment of authorized benefits be made to Dana Group Associates on behalf of the client named below. The undersigned authorizes any holder of medical information about the client to release the Health Care Financing Administration and its agents any information needed to determine those benefits payable for related services.

Signature of Client	Name of Client	Date
Signature of Responsible Party	Name of Responsible Party, Printed	Date

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Fee Schedule and Financial Policy

Clinical Services

90791	Initial Evaluation	45-50 minutes	200.00
90832	Individual Psychotherapy	30 minutes	100.00
90834	Individual Psychotherapy	45-50 minutes	145.00
90846	Family/Couples Psychotherapy w/o client	45-50 minutes	160.00
90847	Family/Couples Psychotherapy w/client	45-50 minutes	160.00

Medication Management Services

90792	Initial Evaluation	45-50 minutes	200.00
99214	Individual Psychotherapy w/medication mgmt	25 minutes	105.00
99215	Individual Psychotherapy w/medication mgmt	40 minutes	155.00
99213	Medication Management Follow Up	15 minutes	85.00

Consultant Services (Self-Pay - Non-insurance based services)

Brief letters to schools, employers, etc.	45.00
Written Reports by request	75.00 per page
Written Referrals – Diagnostic Letters	(225.00 Maximum)
Consultations (telephone, school, agency, etc.)	45.00 @15min
Including travel time (in excess of 10 minutes)	180.00 per hour
School Advocacy and Coaching	200.00 per hour
School Safety Evaluation	150.00 per hour
Substance Abuse Evaluations (1-4 Sessions)	150.00 per session
Court-related Parenting Coordination	150.00 per hour
Court-related Reports	100.00 per page
Parenting Coaching	125.00 per hour

Educational, Speech & Language Therapy Services (Non-insurance based services)

Cogmed Working Memory Training Program		1,500.00
Psycho-educational/Social Skills Groups		55.00/session
Educational		
Written Reports	(Progress, Discharge)	75.00 per hour
File Review		90.00 per hour
School Consultation	(Includes travel time/round trip)	100.00 per hour
Phone Consultation		90.00 per hour
Academic consultation, Skill Development		100.00 per hour
ADD/Educational Coaching		100.00 per hour

The Fee Schedule Is Subject To Change At The Discretion Of Dana Group Associates

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Fee Schedule and Financial Policy Continued

Client Payment Policy: Co-Payments and Self-Payments

Client Payment is always Due At Time Of Visit
This Includes Co-Payments Or Full Payment For Out-Of-Network Plans
This office Does Not Bill for Co-Payments or Self-Payments
We require that a Debit Card, VISA, Discover or MasterCard payment authorization be placed on file with our office to process the payments due at time of visit.

Cancellations and Missed Appointments

24-Hour Notice Is Required Or The Cancellation Fee of $100 Is Charged.

A Missed Appointment Fee of $100 is charged

Psycho-Educational/Social Skills Group Billing Policy

The Fee For A Group Session Is Charged Regardless Of Attendance.
Reserving an ongoing space in a group is a commitment for both client and therapist. We cannot re-book a client's absence from a group as we might an individual or family session. Consequently, charges will be made for each group session regardless of whether the individual has attended unless stated when joining the group. All Group Fees are billed as 'out-of-pocket' for the client. We do not accept insurance benefits for Group Billing. There are two fee rates available; 1) $50 per session when paid four weeks in advance or 2) $55 per session when paid at time of session.

Testing Services

The Testing Fee Schedule Is Available Upon Request.
Some testing services require prior authorization from you insurance carrier; however, some or a portion of the services may not be covered at all. If not covered, payment in full for these testing fees is due at the time of testing.

Health Insurance

We Accept Most Tufts, BCBS, HPHP, PacificCare, UBH and PHCS for Various Commercial Insurances.
Insurers do not reimburse for non-cancelled, non-attended appointments. Therefore, you will be billed for appointments cancelled with less than 24-hour notice or any non-attended appointment. Benefits for MANAGED CARED products require authorization prior to the first session.

Please Check With Your Insurer to Determine Policy Limits, Co-Payments, and Whether Your Insurance is a "Preferred Provider Panel' in Which We Participate.
Your insurance benefit relationship is a "direct contact" with you and your insurer. You are directly responsible for the initial authorization, co-payments or any uncovered or out-of-network fees. It is also your responsibility for tracking your visits for you. However, we will assist you in the authorization and benefit process.