PATIENT REGISTRATION FORM

Date: ____ / ____ / ____ Doctor's Name:_____

Patient Name: _____

Parent/Responsible Person For Account & Treatment:_____ Relationship: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Telephone# @ Home: (_____) _____ @ Work#: (_____) _____

Cell Phone # (_____) _____ Email: _____

Where can a message be left regarding appointments? _____

Patient Social Security Number: _____ - _____ - _____ Birthday: _____ / _____ / _____

Employer or School: _____ Occupation / Grade: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Telephone# @ Home: (____) _____ @ Work: (_____) _____

Primary Physician Name and Phone: _____

Whom may I thank for referring you? _____

FINANCIAL & INSURANCE INFORMATION

Will you be paying for visits without using any insurance (self-pay)? YES NO (If yes, please skip insurance section)

Insurance Company: _____ PPO?_____ Telephone#: _____

Insured Name: _____ Relation to Patient: _____

Social Security Number: _____ - _____ - _____ Insured Birthday: _____ / _____ / _____

Group #: _____ ID # or Policy #: _____

Employer Name & Address: _____

Address of Insured if different from Patient: _____

I understand that my Doctor may bill to my insurance plan directly as a courtesy to me. I furthermore understand that I am fully responsible for all charges for visits with my Doctor and that includes any charges which cannot be billed to my insurance plan including phone consultation time, or missed appointment charges. I finally understand that my Doctor has a 24 hour cancellation policy and if I do not cancel a scheduled appointment with at least that much notice that I am fully responsible for all charges for that reserved time.

_____ _____

Signature and Printed name of person financially responsible for account Date

Financial Policy

I am committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of the Financial & Practice Policies are important to our professional relationship. Please discuss this with me directly if you have any questions regarding this.

- If Dr. Virruso is a participating provider of your insurance network, then she is happy to bill your insurance company directly as a convenience offered to you. You must keep Dr. Virruso informed immediately regarding any changes to your insurance if we are billing to your plan on your behalf.
- If payment is not received from the insurance carrier or other responsible 3rd party within 90 days, the outstanding balance will be transferred and billed to you directly.
- If you do not have insurance, Dr. Virruso is not in your insurance network, &/or you do not have your insurance card, then full payment is due at the time of service. Dr. Virruso accepts payment in the forms of check, cash, and some forms of e-payments.
- All patients must complete and update the Patient Registration Form & associated forms on an annual basis.
- 24 hours minimum notice is required for a cancellation of a reserved session time, or YOU WILL BE CHARGED the full session fee of **$165.00**. Please be aware that your insurance will not accept claims for cancellation / missed session fees.

Self Pay

All Payments are due in full at the time of service unless prior arrangements have been made.

Insurance Pre-Authorizations

All co-payments are due at the time of service if we are billing directly to your in-network insurance plan. If Dr. Virruso is a participating member of your insurance plan, you will not be billed outside of your co-payments, co-insurance, and deductible as long as Dr. Virruso has the necessary referrals and authorizations. Please note: You must pre-authorize your first session if required by your insurance. Dr. Virruso may be able to obtain this authorization when she verify your benefits; however, if your insurance does not cover a visit prior to the first authorization, you will be responsible for full payment of that initial visit.

Usual and Customary Rates

Dr. Virruso is committed to provide the best treatment possible for her patients and she charges what has been researched to be well within the usual and customary fees for our area. If Dr. Virruso is not in network with your insurance company, you are responsible for payment in full for a session regardless of any insurance company's arbitrary determination of usual and customary rates.

Please complete if we are billing directly to a plan your Doctor is in network for:

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with

_____

(Name of Insurance Company) and assign directly to **Dr. Elissa Virruso** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that Dr. Virruso may bill to my insurance plan directly as a courtesy to me. I furthermore understand that I am fully responsible for all charges for visits with Dr. Virruso and that includes any charges which cannot be billed to my insurance plan including phone consultation time, or missed appointment charges. I finally understand that there is a 24 hour cancellation policy and if I do not cancel a scheduled appointment with at least that much notice that I am fully responsible for all charges for that reserved time.

_____ _____

Patient Signature Date Responsible Party Signature Date

Elissa M. Virruso, Psy.D.
550 Fox Glen Court Barrington, IL 60010
Phone: (847) 381-9870 Fax: (847) 381-5059
Email: drvirruso@barringtonbehavioralhealth.com

Consent for Email, Text, and Electronic Communications

I authorize Dr. Elissa Virruso to communicate with me in the following ways: (Please Check & Initial):

PATIENT NAME: _____

_____Leave a message on my phone, Fill in ALL that apply:

Home:_____ Cell: _____

_____ Communicate by Email: _____

_____ Communicate by Text: _____

**Please Note: Any communication by phone, text or email are not expected to be in lieu of therapy and may not be HIPAA compliant, and I consent to this form of potentially non HIPPA compliant communication.

EMAIL AND TEXTING:

Because email and texting are inherently insecure, these modes of communications should be utilized sparingly and only for the occasional purpose of scheduling and the like. Please do not email or text content related to your therapy sessions. If you choose to communicate by email or text, there is no contemplation of privacy. While it is unlikely that anyone will see or acquire copies of any such communication, they are, by their nature, not secured. Any text or emails I understand, and do consent to being inherently potentially not HIPPA compliant.

_____ _____ _____ _____

Patient date: Adult Parent / Guardian date: