Bloomfield Consulting, PLLC ______________________________

300 E. Long Lake Road, Suite 130 / Bloomfield Hills, MI 48304 / 248.792.2104 Phone / 248.792.2404 Fax

About Dr. Fadell's Services

Office Hours:

Dr. Fadell has flexible hours of operation, including evenings and Saturdays. The office responsible for insurance billing, Premier Billing Specialists, is open 8:30 AM to 4 PM. Their phone number is 586.751.6034.

Voice Mail / Text / Email Services:

Dr. Fadell's voice mail /text / and email are confidential. You may leave a message, text, or email any time; however, please know that depending on Dr. Fadell's appointment schedule for that day, she may not be able to immediately respond. She makes every effort to return non-emergency calls the same day, although this may be after hours. _____
initials

Confidentiality:

By law, you have the right to confidentiality, which includes your association with Dr. Fadell as well as any information disclosed during therapy sessions. Absolutely no information will be discussed with anyone without your written consent. Even then, this disclosure is limited to the individual, as well as type, of information you designate to be disclosed. The exception to this is when utilizing your insurance benefits to cover your treatment. In this case, your insurance will <u>require diagnostic information before it can process and pay your claim</u>. Please be assured that every effort is made to provide only the minimum information needed to fulfill the insurance's needs. This is required of your contract with your insurance company as they are absorbing the cost of your treatment and have an obligation to ensure that treatment is appropriate and necessary. _____
initials

Informed Consent for Treatment:

Psychological services with Dr. Fadell are voluntary (unless otherwise dictated by the court) and may be terminated by the patient at any time. By signing the Informed Consent for Treatment, you are committing to a collaborative relationship with Dr. Fadell, where your input is of utmost value. Dr. Fadell views treatment as a team effort and strives to ensure that your treatment goals are met. _____
initials

Important Notice to Patients

Insurance Benefits:

Because of the large number and constant changes in insurance policies and benefits, Dr. Fadell and Premiere Billing Specialists make every effort to obtain up-to-date information on your coverage. Unfortunately, in some instances, Dr. Fadell's billing office can only obtain information given to them via your insurance company; therefore, it is important that you, as the patient, also call to verify these benefits. This way, you are fully informed as to your financial responsibility for services. _____
initials

In order to better help us with your insurance benefits, it is your responsibility to learn about your individual plan coverage. You can do this by:

- **<u>Covered Benefits:</u>** Obtain information regarding your *in and out of network benefits* (e.g., some plans allow out of network benefits, which means you can obtain services from a non-paneled provider).

- **<u>Policy Restrictions:</u>** Prior to obtaining services from Dr. Fadell, determine whether your mental health insurance requires *authorization / pre-certification* or if you are exempt due to a pre-existing condition (there is usually a phone number on the back of your insurance card you can call to obtain this information).

- **<u>Percentages/Copays:</u>** Some insurance policies (although not all) require the patient pay a percentage of the cost of their care (i.e., copays) for each visit. These costs are due at <u>the time of service</u>. It is important that patients understand Dr. Fadell has entered into an agreement with your insurance company to accept their allotted amount for services but is <u>required</u> by the insurances to collect the copays as a part of her contract with them. If Dr. Fadell fails to collect the copays dictated by your insurance, she is at risk of losing her good standing with that insurance company and could even be dropped as a paneled provider.

- **<u>Deductibles:</u>** Some insurance polices require the patient first pay a deductible (i.e., a percentage that is determined up front prior to the insurance covering the cost of treatment). The deductible may or may not be linked to mental health services, so please call to find out. If you do have a policy with a deductible, it will be important for you to know how much of your deductible has already been met (these usually re-start at the beginning of each calendar year, although may vary depending on your benefits year). If your deductible has not been met, <u>you are responsible for the full cost of treatment until this has been achieved.</u> Once your deductible has been met, you will only be responsible for the percentage or copay set by your insurance provider

______ initials

Failure to know and understand your policy and insurance benefits may result in you being responsible for all unexpected costs incurred during your treatment.

I have read and fully understand my responsibilities as a patient of Dr. Fadell as they relate to the use of my insurance to cover my treatment.

____
(Patient/Parent Signature) (Date)

____
Laura Fadell, PhD, LP, CSP (Date)
Bloomfield Consulting, PLLC

PATIENT REGISTRATION / ASSESSMENT INFORMATION

Office Use Only	
Date	
Dx	
Account #	
Fee	

Patient Name:____Driver's Lic. #____________________

Home Address:____
(Number and Street) (Apt.)

____
(City) (State) (Zip Code)

Sex: Male Female Date of Birth:____________________ Age:____________

Marital Status: Single Married Separated Divorced Widowed Partnered

Home Phone:_____________________________ Cell Phone:_____________________________

Work Phone:_____________________________ Email:_________________________________

Employer / School:__________________________________ Job Title / Grade:________________

Emergency Contact:_________________________________ Phone:__________________________

Referred by:____

Physician:____ Phone:___________________________

Please provide a brief summary of the concerns that brought you here today:________________

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BILLING INFORMATION

In order for us to bill your insurance company for you, the following must be completed:

Insurance Authorization to Release Information

I authorize the release of any medical information necessary to process insurance claims. This may include, but is not limited to, Dr. Fadell's records, billing, or case summary.

____

(Patient / Guardian Signature) (Date)

Assignment of Insurance Benefits

I authorize and assign payment of medical benefits to Bloomfield Consulting, PLLC / Dr. Fadell for the services rendered.

____

(Patient / Guardian Signature) (Date)

INSURANCE INFORMATION

Primary Insurance Name:____

Address:____
(Number and Street) (City) (State) (Zip Code)

Telephone Number: ( )____

Subscriber (name of policy holder):_________________________________

SSN of Subscriber:_____________________ Birth Date of Subscriber:____________

Policy Contract # / Enrollee ID:_______________________ Group #:__________

Secondary Insurance Name:____

Address:____
(Number and Street) (City) (State) (Zip Code)

Telephone Number: ( )____

Subscriber (name of policy holder):_________________________________

SSN of Subscriber:_____________________ Birth Date of Subscriber:____________

Policy Contract # / Enrollee ID:_______________________ Group #:__________

IMPORTANT FEE / BILLING INFORMATION

1. My fee will be established with Dr. Fadell either prior to, or at, the first session.

2. If using my insurance, I agree to pay all copays and/or deductibles at the end of each session.

3. Fees can be paid via cash, check, or charge (i.e., Visa, Master Card, Debit, HAS).

4. A **$25.00** charge will be made to your account and must be paid prior to your next appointment for checks returned due to insufficient funds. Dr. Fadell cannot accept personal checks after a check has been returned due to insufficient funds.

5. Payment for services is due at the time of your visit. If using your insurance, Dr. Fadell's billing service will bill your visits to your insurance company; however, if your deductible (if you have one) has not yet been met, payment for the full cost of the visit will be due at each appointment until your deductible has been met. This is not Dr. Fadell's policy, but the policy of **your insurance company**.

6. Dr. Fadell requires at least **24-hours notice** if you need to cancel or change an appointment. Missed appointments without this notice will be billed to you at the cost of $150.00. Insurance does not pay for missed appointments; and this must be paid prior to your next appointment, unless otherwise discussed with Dr. Fadell.

   Twenty-four hour notice is important because Dr. Fadell frequently has a cancellation list – people waiting for an opening. If not given this notice, she cannot contact other patients who may be waiting to get in to see her.

7. Dr. Fadell will, at times, provide telephone sessions if appropriate. These sessions are not covered by insurance and are billed at $150.00 for 45-minutes.

8. All office sessions are generally scheduled on the hour (e.g., 9:00, 12:00, 6:00, etc.) and last **55-minutes**. Dr. Fadell keeps to a timely schedule so as to not get behind and inconvenience others by causing them to wait past their start time.

I have read the above policy on payment of fees and billing, late cancellations, phone sessions, and start/stop times.

Patient Signature:____
(18-years and older)

Parent (Guardian) Signature:____________________________________
(If patient is a minor)

Dr. Fadell's Signature:____

Unless otherwise arranged, a Visa/MasterCard/Debit Authorization is required for services with Dr. Fadell. Please know that these authorizations are kept in a locked file cabinet, in a locked file room and not kept in a database that could be compromised online. Cards are run on Saturdays for any outstanding charges incurred that week. Please don't hesitate to ask Dr. Fadell any additional questions you have regarding this policy.

Visa/MasterCard/Debit Authorization

I, ____________________________________ give Bloomfield Consulting and Dr. Fadell authorization to bill by Visa/MasterCard/Debit card for services, which include copays, deductibles, and missed appointment fees (if applicable) rendered at this facility for:

____

(Patient's Name – Please Print)

I further understand that because all payments are due the day of services, my card may be billed as early as that same day.

____

(Cardholder's Signature) (Date)

****

Cardholder's name as it appears on the card:

____

(Please Print)

Account Number: ____

Expiration Date:______________________ Security Code: __________

Billing Address for Credit Card (if different from Patient's home address):

____

____

______Yes, I would like a statement mailed to me

_______No, I would not like a statement mailed to me

Bloomfield Consulting, PLLC______________________________________

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Consent to Use or Disclose Protected Health Information

By signing this form, I consent to the use or disclosure of my Protected Health Information by my provider, Bloomfield Consulting, PLLC / Dr. Laura Fadell, to my insurance provider for the purpose of billing for services.

Protected Health Information means health information (including identifying information about me) collected from me by Dr. Fadell. It may include information about my past, present, or future physical or mental health or condition, the provision of my health care, and payment for my health services.

Bloomfield Consulting, PLLC / Dr. Fadell agrees to maintain my Protected Health Information in accordance with the practices described in the Privacy Notice. This notice also describes my rights with respect to the use and disclosure of my Protected Health Information.

I acknowledge that I have been given a copy or the Privacy Notice and/or I have been given an opportunity to review the Privacy Notice prior to signing this consent. The Privacy Notice is also posted on Dr. Fadell's website (www.drfadell.com), in clear view for patients to read.

I understand that this information may be needed to:

- Plan my care and treatment
- Communicate among the various health care professionals involved in my care
- Provide information to my health insurance company or plan for billing purposes
- Obtain payment from my health insurance company or plan
- Assess the quality of my care and review the care provided by Dr. Fadell

I also understand that I have the right to revoke the Consent, in writing, at any time, except to the extent that Bloomfield Consulting, PLLC / Dr. Fadell has taken action in reliance upon this consent.

I further understand I have the right to request a restriction as to how my Protected Health Information is used/disclosed to carry out treatment, payment, or health care operations of Bloomfield Consulting, PLLC / Dr. Fadell. I realize that Dr. Fadell is not required to agree to a restriction that I may request. However, if Dr. Fadell does agree, the restriction must and will be honored by Bloomfield Consulting, PLLC / Dr. Fadell.

Restrictions:____

____

(Signature of Patient/Guardian) (Relationship to Patient) (Date)

____

(Signature of Witness/Staff) (Date)

Withdrawal of Consent: This consent is revoked on:________________________

(Date)

____

(Signature of Patient/Guardian) (Date) (Signature of Witness/Staff) (Date)