INFORMATION & AGREEMENT VERIFICATION FORM

_____ (initial)
By initialing, I verify an understanding that I am required to pay my co-pay/co-insurance payment at the time of service and agree to do so. I understand I will be charged a fee (subject to change) for failure to do so. I understand that further sessions will not be held/scheduled after missing two consecutive co-pays until the co-pay balance is paid in full.

_____ (initial)
By initialing, I verify an understanding that I am required to pay my deductible payments in a timely manner, preferably at the time of service. I also understand that unpaid deductible payments may result in an interruption of services until the deductible balance is paid in full. I understand it is my responsibility to educate myself about my insurance company's deductible time of year and policies and agree to do so.

_____ (initial)
By initialing, I verify an understanding that I will be billed for miscellaneous (non-session or out-of-office services at the above rate provided by Dr. Boghosian that he deems clinically indicated or that I request. I understand that insurance companies do not usually cover such charges. I agree to pay for miscellaneous services received as part of my therapy.

_____ (initial)
By initialing, I verify that I am responsible for notifying Dr. Boghosian's office at least 24 hours in advance of cancellations (except in cases of illness/ emergency). I understand that failure to do so will result in a fee. I understand that after two no-shows, those fees must be paid in full in order to continue treatment.

_____ (initial)
By initialing, I verify that I am responsible to maintain my outstanding payment balance under $300. I agree to pay down the payment balance when it exceeds $300 within one month from the statement date indicating said balance. I understand that failure to do so will result in an interruption of treatment and that I may not schedule/retain further appointments until the balance is maintained under $300. I understand refusal to pay will result in being sent to collections.

_____ (initial)
By initialing, I verify that if my insurance coverage changes, if I no longer have insurance covering behavioral health services, or if Dr. Boghosian elects to discontinue his professional relationship with my insurance provider, I will either have to contact my insurance about negotiating a single-case agreement, switch to self-pay rates, or be referred to a provider who is paneled with my insurance or who provides services on a sliding fee basis.

_____ (initial)
By initialing, I verify that I authorize Sara Boghosian, PhD, PC and/or its affiliates to contact my insurance company and/or myself to fulfill the completion of my claims process as identified and explained in the agreement.

_____ (initial)
By initialing, I acknowledge that I have received the Notice of Privacy Practices in either electronic and/or printed format. I acknowledge that my privacy rights have been explained to me in a manner that I can understand them. I also acknowledge that Dr. Boghosian has given me an opportunity to discuss any questions or concerns associated with my privacy rights.

_____ (initial)
By initialing, I acknowledge that my mobile phone number is: (_____) _____ - _____. I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes.

With my signature, I verify that I have read, understand, and agree to this information and agreement policy effective 17 April 2017. I understand this policy supersedes any and all former policies/statements. My signature also verifies that I was provided a full and complete copy of the information and agreement policy, including billing and contact information, and an opportunity to discuss any questions or concerns with Dr. Boghosian.

Patient's Name (printed)	Signature of Patient (or Parent/Guardian if minor)
Parent/Guardian Name (if patient is a minor)	Name of Person accepting financial responsibility
Signature of Person accepting financial responsibility	Today's Date

APPOINTMENT REMINDERS & PATIENT PORTAL

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a voice message) before your scheduled appointments.

You can also enjoy the convenience of viewing your scheduled appointments, account balance, and other tools located in our secure patient portal. Simply visit www.therapyappointment.com to find your healthcare provider and set up your patient portal. Once established, you can access your patient portal by going to www.schedule.care.

Your name: _____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters and/or numbers only)

Requested temporary password: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(must contain both letters and numbers)

(After you log in, you will be asked to change this to a permanent password)

Your email address: _____

Your home phone number: _____

Your cell phone number: _____

How would you like to receive appointment reminders? (initial one)

_____ via a text message to my cell phone (normal text message rates will apply)

_____ via an email message to the email address listed above

_____ via an automated voice message to my home phone number listed above

_____ Do not send reminders. I'll remember my appointments on my own.

NOTES: (1) If requested, appointment reminders are sent as a courtesy. Missed appointment fees still apply if, for any reason, the reminders cannot be delivered. (2) Appointment information may be classified as "Protected Health Information." By my signature, I am requesting that reminders be handled as I have noted above.

Signature _____ Date _____