Suzanne R. Benko, MFT, APC
25301 Cabot Road, Suite #114
Laguna Hills, CA 92653
(949) 951-8369 x2 (949) 583-7045 Fax

PATIENT REGISTRATION

Date_____ Referred By:_____

Patient Information

Name_____ E-Mail Address_____

Address_____

City_____ Zip_____

Home Phone_____ May I leave a message? _____

Work Phone_____ May I leave a message? _____

Cell Phone _____Which is your preferred contact? _____

Date of Birth_____ Age_____ Social Security #_____

Marital Status (If under 18 years old, include this information on your parents)

Spouse/Parent Name(s) _____

Married_____ Single _____ Separated_____ Divorced _____ Widowed _____ How long? _____

Committed Relationship _____ How long? _____ Living Together? _____

Children's/Siblings Names and Ages

1. _____ _____ 4. _____ _____
name age name age

2. _____ _____ 5. _____ _____
name age name age

3. _____ _____ 6. _____ _____
name age name age

Anyone else living in the home?

Name_____ Relationship _____
Is someone other than patient responsible for this account? No ____ Yes ____
If so, please complete the following:

Name _____ Phone _____

Address_____

Insurance Information

Please provide all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information for both carriers. Please list all numbers as shown on your insurance card. Please check your insurance policy regarding waiting periods, deductibles, or pre-existing clauses. IF YOUR COVERAGE IS CONTINGENT UPON A DOCTOR'S REFERRAL, IT IS YOUR RESPONSIBILITY TO OBTAIN THE NECESSARY REFERRAL.

Primary Carrier_____ Secondary Carrier_____

Address_____ Address_____

_____ _____

City State Zip City State Zip

Phone Number_____ Phone Number_____

Insured_____ Insured_____

Relationship to Patient_____ Relationship to Patient_____

Insured's I.D. Number_____ Insured's I.D. Number_____

Group #_____ Group #_____

Insured's SS#_____ Insured's SS#_____

Insured's Date of Birth_____ Insured's Date of Birth_____

Insured's Employer_____ Insured's Employer_____

Effective Date_____ Effective Date_____

Authorization # _____ Authorization# _____

Co-Pay Amount _____ # sessions per year _____ Co-pay Amount _____# sessions per year _____

I do _____ do not _____ have insurance coverage by a secondary carrier.

_____ _____

Signature of Patient or Authorized Person *Date*

In order for us to submit a claim for payment for the services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE PROVIDER INDICATED ON THE CLAIM. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of my signature is as valid as the original.

_____ _____

Signature of Patient or Authorized Person *Date*

Medical Information

Physician's Name_____ Phone _____

Date of last physical exam (approx) _____Medical Conditions, Illnesses, Surgeries _____

_____

Current Medications _____

Previous mental health treatment:

Counseling/therapy ( ) yes ( ) no Approx. date _____

Name of therapist(s) _____

Reason for treatment _____

Psychiatric medications _____

Substance abuse treatment? _____

Family history of substance abuse or psychiatric problems _____

_____

Please give a brief statement of current problems and reasons which bring you to therapy at this time.

_____

_____

_____

_____

Education/Employment

If you are currently attending school:

Name of school _____

Grade _____ Approximate GPA _____

If you have completed school:
What was your highest grade or degree you achieved? _____

Employed by _____How long? _____

Title/Position _____

Confidentiality

All personal information is confidential, including the fact that you are a client here. We conform to federal and state laws regarding therapist/client confidentiality. No records of information will be shared with anyone without your expressed written permission to do so. Exceptions to this policy as we are mandated by law to report include the following:

1. If you threaten grave bodily harm or death to another person or yourself;
2. If a court of law issues a legitimate subpoena;
3. If child abuse, sexual abuse, or child neglect is suspected;
4. If physical abuse is suspected with a person 65 years or older;
5. If physical injury, abuse and/or assaultive behavior toward a spouse is suspected.

Letter of Financial Agreement

Each of our sessions is scheduled to last fifty (50) minutes. You will not be charged for a session if you cancel your appointment at least twenty-four (24) hours in advance. IF YOU FAIL TO KEEP AN APPOINTMENT OR DO NOT CANCEL WITHIN TWENTY-FOUR (24) HOURS OF THE SCHEDULED APPOINTMENT TIME, YOU WILL BE CHARGED THE FULL SESSION FEE.

I am available to return calls during the day and evening hours. However, in case of an emergency after those hours, you are asked to call 911 if you need immediate attention. If telephone contact is required frequently or for extended periods of time, you may be charged a full session fee.

IT IS CUSTOMARY TO PAY FOR SERVICES AT THE TIME OF EACH SESSION. Payment for services can be made by cash, check, or credit card (VISA or MasterCard). Medical insurance billing is provided by my office as a courtesy only. YOU ARE RESPONSIBLE FOR YOUR ACCOUNT. If payment in full is not possible at the time of service, please discuss arrangements for payment BEFORE your session.

Although I will file insurance claims on your behalf with your insurance carrier, it is important for you to remember that YOU CARRY THE INSURANCE COVERAGE AND PAYMENT FOR SERVICES IS ULTIMATELY YOUR RESPONSIBILITY. If services were rendered to you, then you are responsible for payment of your account regardless of the amount your insurance covers. If your account becomes delinquent, you may be responsible for reasonable attorney's fees, court costs, collection agency costs, and interest at 1.5% per month. For accounts that are past due and delinquent over 90 days, a $25 monthly late fee will be applied to the outstanding balance on each monthly billing cycle.

FEE SCHEDULE:

New Outpatient Assessment and Evaluation	160.00
Individual/Family/Couple Therapy	135.00
Group Therapy (90 minutes)	75.00
Hospital Individual/Family Therapy	175.00
Forms, letters, reports (prorated 50 minutes)	125.00

**A $25 fee will be charged for any check returned by the bank for insufficient funds

I, the undersigned, have read this letter of financial agreement and agree to its terms and conditions.

Client Date

Therapist Date

CREDIT CARD INFORMATION AND AUTHORIZATION
(To be completed even if sessions are to be paid by cash, check, or insurance)

I hereby authorize Suzanne R. Benko, MFT, APC to charge my counseling sessions to the account shown below. I understand that I will be charged the full session fee if I do not cancel within twenty-four (24) hours of the scheduled appointment time. I understand that a $2.50 transaction fee will be applied to each charge.

____ VISA

____ MASTERCARD

Name on Card _____ Billing Address Zip Code _____

Account Number _____

Expiration Date _____ V Code _____ (3 digit code on back of card)

Cardholder Signature _____