Mark G. McConville, Ph.D.
Clinical Psychologist

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216-751-1007
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Name of Client :
(This is the person to be identified as "the patient" on health insurance claim forms.)

Age: Date of Birth:

Responsible Party Name:

Address:

Phone #s	Home:	Work:	Cell:
May we leave Messages at this #?	Y N	Y N	Y N

Email address:

May we use this email address to communicate re practical/business matters, such as appointment scheduling? _____ yes _____ no

Occupation:

Place of Employment:

Who referred you to our practice?

Payment and
Health Insurance.

Please Read Carefully! My office handles health insurance differently than many health care providers. By choice, **I have not contracted with any insurance companies, and consequently am an "out of network" provider.** If you are relying upon your health insurance to cover or defray the cost of our services, we recommend that you check your policy's provision for out of network providers. Also, I am an "opted out" provider and do not accept Medicare.

We ask our clients to pay for services directly, and to submit health insurance claims for reimbursement. It will be **your** responsibility to manage the mechanics of your insurance claim. Accordingly, we do not accept direct assignment of payment from insurance carriers. Our role will be to assist you in any reasonable way possible. We will supply you monthly with a HCFA (universal) health insurance claim form, completed with all necessary provider information and codes. You can then submit these claim forms to your carrier directly for reimbursement.

We will do our best to assist you if you have questions regarding matters related to billing and insurance. However, we stress that the mechanics and management of collecting from health insurance carriers are the client's responsibility.

Please check one:

____ Please send a monthly insurance claim form with my bill

____ I do not request a monthly insurance claim form

Insurance information:
Insurance carrier:

Insured party's name:

I.D. #:

Group #:

Your Initial Visit

You can schedule your initial visit by linking to my Appointments Available calendar, and then emailing (markmcconville1@mac.com) to request your appointment. Your appointment request will be confirmed by return email.

Payment for your initial visit is expected at the time of your appointment.

Payment Method

If you wish to pay your bill monthly by credit card:

MasterCard_____ Visa_____

Card Number:

Expiration date:

Name as it appears on card:

Street address associated with card:

Signature: _____

If another party is responsible for paying all or part of your charges, it is necessary for that individual to also complete a copy of our Office Billing forms. Please have that individual contact our office by phone at 216-751-1007, or by email at markmcconville1@mac.com

Mark G. McConville, Ph.D. and Associates
PROFESSIONAL SERVICES AGREEMENT

Ohio State Psychology Board regulations require that all clients are fully informed regarding the costs of professional services. Following is a list of fees and a summary of our billing practices. We ask that you read this material carefully, and sign below to signify your acceptance of these terms.

Office visits are 45 minutes. Extended time office visits are billed pro rata.

SERVICE	FEE
Office visits (50 min):	$175
Extended time visits:	Office visit rate, pro rata
Telephone/email consultation:	Office visit rate, pro rata

For Monthly Billing, we ask that you settle your account within 30 days of your initial billing.

Forty Eight hours (two business days) cancellation notice is required for appointment times reserved. Should you cancel with less than 48 hours notice, we will do our best to fill the appointment hour. If we are unable to, your account will be billed the fee for the time reserved.

I have read and understand the above, and accept full financial responsibility for fees incurred within the framework of this agreement.

I have received and read the Privacy and Confidentiality Notice Form.

_____ Your name (Please print)

_____ Your Signature