Mark McConville, Ph.D. & and Associates

Marlene Moss Blumenthal, Ph.D.
Belvoir Place, Suite 210
21403 Chagrin Boulevard
Beachwood, Ohio 44122
(216) 513-1805
marloblum@yahoo.com

Name of Client_____
(the person to be identified as "patient" on health insurance claim forms)

Age _____ Date of Birth _____

Responsible Party:

Name _____

Address _____

_____

Phone Nos. Home_____ Cell_____Work_____

E-Mail Address: _____ for appt or billing messages

Occupation _____
Place of
Employment _____

Who referred you to our practice? _____

The HIPAA privacy rule gives individuals the right to choose how to be contacted. Please check all that apply:

__ Home Telephone _____
- __ OK to leave message with detailed information
- __ Leave message with call back # only.
- __ Other_____

__ Written Communication
- __ OK to mail to my home address.
- __ OK to mail to my work address.
- __ OK to fax to this # _____
- __ OK to e-mail to _____

__Work Telephone _____
- __ OK to leave message with detailed information
- __ Other_____

__ Other _____
- __ Leave message with call back # only.

PAYMENT, HEALTH INSURANCE, AND VISITS

General Information:

Our office handles health insurance differently than many health care providers**. By choice, we have not contracted with any insurance companies, and consequently are seen as an "out of network" provider.** You may wish to check your policy's provision for out of network providers, to see if Dr. Mark McConville is listed. In addition, we opted out of 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 details of submitting your insurance claim. Accordingly, we do not accept direct assignment of payment from insurance carriers. We will assist by supplying you monthly with a HCFA (universal) health insurance claim form, completed with all necessary provider information and codes. You can submit these claim forms to your carrier directly for reimbursement**.**

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: _____

ID#: _____

Group#:_____
Other: _____

Appointments:

You can schedule your initial visit by linking to my Appointments Available calendar and then e-mailing me (marloblum@yahoo.com) to request your appointment. I will confirm your request by return e-mail.

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

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PROFESSIONAL SERVICES AGREEMENT

The Ohio Psychology Law requires that all clients be informed of fees and billing practices. We ask that you read this information carefully, and raise any questions or request clarification as needed.

Appointments:

Office visits are 50 minutes. Longer visits are arranged when indicated.

Fees:

Office visits (50 minutes):	$150
Extended office visit:	Office visit rate, pro rata
Telephone/email consultation for other than routine matters:	Office visit rate, pro rata

Office visit cancellation (48 hours notice required)

(In the event of a cancellation with less than 48 hours notice, we will do our best to fill that appointment hour. If we are unable to do so, we will expect payment for the appointment time reserved (ATR). Fees for appointment time reserved cannot be submitted for insurance reimbursement.)

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

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

I have received the information about Privacy and Confidentiality.

Your name (please print): _____

Your signature: _____

Date: _____