Carolinda S Sterczala, LICSW

30 Domino Drive Ste 2
Concord MA 01742

OFFICE: 978 771-4154
BILLING 978 264-4851

Patient Registration Form

Name: _____ **Date of Birth:** _____ **Sex:** __M __F **Marital:** __S__M__D__W

Address: _____ **City**_____ **State** ____ **Zip** _____
Patient Bills to: _____ **Address** (If different)_____
Client Soc. Sec # _____ **Employer:** _____
Home Phone: _____ **Number that messages may be left at :** _____
Emergency Contact Name: _____ Contact Phone:_____
Referred By: _____ Primary Care Physician _____

Clinical Services:

Initial Evaluation	$ 170
Individual Psychotherapy	$ 150
Individual Therapy half session	$ 80

*** Neurofeedback Sessions**

Neurofeedback Sessions:

Initial Evaluation Session:	$150.00
Neurofeedback session	$150.00

No Show/Late Cancel

Failure to keep a scheduled appointment without **48** hours advance notice will result in a $75.00 fee due at your next appointment. These are your responsibility and may not be paid by a health savings or flexible spending account card.

Other Consultative Services

Written Reports by request $ 150.00 Per hourly rate
Consultation (phone, school, agency, another therapits, or legal) $ 150.00 per hour
Travel time: First fifteen minutes or 30 minutes round trip travel (no charge) but thereafter, $ 150 per hour.

Payment Policy:

- Payment is expected prior to or at the time of service for all self-pay clients.
- Payments can be made by **cash**, or **check** made payable to: **Carolinda Sterczala, LICSW**, or by credit card at your visit.
- **Appointments cancelled without 48 hours notice are the responsibility of the patient.** Charges for missed appointments or late cancellations must be paid in full at the next appointment.

I understand that Carolinda Sterczala, LICSW, utilizes a billing person who is also bound by state and federal rules of confidentiality. **I understand that I am responsible for all charges incurred.**

_____ _____
Signature of Patient or Adult Guardian (if minor) **Date**

Privacy Practices Acknowledgement:
I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ **Signature** _____ **Date**_____

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Date of First Appointment: _____ DX: _____

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FEE SCHEDULE AND FINANCIAL POLICY

Clinical Services (May be Covered by Insurance):

Initial Evaluation (90791):	$ 170
Individual Psychotherapy (90834):	$ 150
Individual Therapy half session (90832)	$ 80
Family/Couples Therapy (90847):	$160

Non Insurance Covered Services (SELF PAY)

Neurofeedback Sessions:

Add on to Billed therapy session: $100.00

Neurofeedback session stand alone $150.00

No Show/Late Cancel fee $75.00

Consultative Services (Not Covered by Insurance)

Written Reports by request $ 150.00 Per hourly rate

Consultation (phone, school, agency, another therapist) $ 150.00 per hour

Travel time: First fifteen minutes or 30 minutes round trip travel (no charge) but thereafter, $ 150 per hour.

No Show/Late Cancels (Not Covered by Insurance)

Failure to keep a scheduled appointment without **48** hours advance notice will result in a $75.00 fee charge due at your next appointment. These may not be billed to your insurance company but are your responsibility.

Payment Policy:

- Payment is expected prior to or at the time of service for all self-pay clients.
- Insurance deductibles, and copays are due at the time of service if known. Payments can be made by **cash** in the exact amount or **check** made payable to: **Carolinda Sterczala, LICSW** , or by credit card at your visit.
- **Appointments cancelled without 48 hours notice are the responsibility of the patient.** Charges for missed appointments or late cancellations must be paid in full at the next appointment.

Health Insurance:

- Please check with your insurer to determine policy limits, copayments, deductibles and whether your insurance for mental health is a "preferred provider panel" in which I participate. Your insurance benefit relationship is a "direct contract" between you and your insurer. Therefore you are responsible for knowing the number of sessions (or dollar amount) your policy covers, if pre-authorization is required, and at what level I am covered under your insurance.

I have read and agree to Carolinda S Sterczala LICSW's Financial Policies. Please note that Fee Schedule Increases may occur based on increased costs but you would be notified in advance of any change.

____
Patient or responsible party

____
Date

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Privacy Practices Acknowledgement:

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Name____________________ **Signature** ________________________ **Date**__________