Family Connections Counseling Services, LLC
Penny L. Sprecher, Ph.D.
Clinical Psychologist

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Reply to: P.O. Box 1482
Chesterfield, VA 23832
Email: Office@fccsva.com

PATIENT CHART INFORMATION

Date: _____ Chart Number: _____

Patient Name: _____
Last First Middle

Patient Address: _____
Street or PO Box City State Zip Code

Patient Phone: (____) _____
Area Code Home Work Cell

Social Security: _____ Relationship to Insured: _____
(Spouse, Child, Self)

Date of Birth: _____ Sex: M / F

Employer: _____

Are you Primary Insured? Y / N If No, then who? _____ DOB: _____

Primary Insured's Address: _____
Street or PO Box City State Zip Code

Primary Insured's Employer: _____

Primary Insured's Employer Address: _____
Street or PO Box City State Zip Code

Primary Insured's Employer Phone: _____

Nearest Relative Not Living With You: _____
Name Phone

_____
Address City State Zip Code

How will you be paying for your visit today? _____Cash _____ Check _____ Other

EAP Authorization #: _____

Insurance Company: _____

Policy #: _____ Identification #: _____

Insurance Company Provider Phone Number: _____

Patient Chart Information *(continued)*

I agree to the following forms of communication knowing that Family Connections Counseling Services, LLC and/or Penny L. Sprecher Ph.D. may leave his/her name and information on my voicemail about my appointments and billing. Please provide contact information for all to which you agree:

Home: _____ Work: _____ Cell: _____

Email: _____

INSURANCE RELEASE AND ASSIGNMENT

I authorize Family Connections Counseling Services, LLC and/or Penny L. Sprecher Ph.D. to release and submit medical information regarding diagnoses, treatment, consultations, prescriptions, and medical history to my insurance company, Medicare, Medicaid or other third party payor which I may be entitled or its authorized agents or representatives for the purpose of determining benefits and facilitating payment.

I request Family Connections Counseling Services, LLC and/or Penny L. Sprecher Ph.D. to submit claims on my behalf to my insurance company, Medicare, Medicaid or other third party payor which I may be entitled for my care and authorize disclose of health information to the extent necessary to obtain payment for services.

In consideration of the health care services provided, I assign and authorize my insurance company, Medicare, or other third party payor to make payments directly to Family Connections Counseling Services, LLC and/or Penny L. Sprecher Ph.D.

_____ _____ _____
Client/Parent/Guardian Date Witness

RELEASE OF INFORMATION TO REFERRING AGENCY AND TREATING PHYSICIAN

I authorize Family Connections Counseling Services, LLC and/or Penny L. Sprecher Ph.D. to release medical information regarding diagnoses, treatment, consultations, prescriptions, and medical history to the referring provider and/or treating physician.

_____ _____
Referral Agency Phone

_____ _____
Treating Physician Phone

_____ _____ _____
Client/Parent/Guardian Date Witness

NOTICE: THIS IS A CONTRACT FOR PROFESSIONAL SERVICES

I understand any bill not paid in 30 days may be subject to a finance charge of 25% and I agree to pay the same. If my account is referred to a collection agency or attorney, I agree to pay all costs of collection and expense including all attorney fees.

Cancellations made less than 24 hours in advance or failed appointments are $50 for a psychological evaluation appointment and $35 for psychotherapy/follow-up appointment. This fee is not billed to or paid by insurance companies. Payment for these appointments will also be due within 30 days of the bill and cannot be accumulated on a payment plan.

I have read and fully understand all the information on this form.

_____ _____ _____
Client/Parent/Guardian Date Witness