Peter J. Somers, Ph.D., LP

Psychological Consultation / Assessment / Teletherapy

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Winnebago, MN 56098
petersomers.com

612-396-1699
Fax: 507-893-3031

REGISTRATION INFORMATION

Date_____ Home phone_____ Cell phone_____

E-mail_____

Client_____
Last Name First Name Middle Initial

Responsible Party (if client is a minor)_____

Street Address_____

City_____State_____Zip_____

Sex_____ Age_____ Birthdate_____ Marital Status_____

Name of Insurance Company_____

Policy Number_____ Group Number_____

Who is responsible for this account?_____

Name of responsible party's employer_____

Relationship to client_____ Birthdate_____

Name of secondary insurance company (if applicable)_____

Policy # of secondary insurance_____ Group Number_____

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In case of emergency, who should be notified?_____

Phone_____ Relationship to client_____

(OVER)

AUTHORIZATIONS AND SIGNATURES

Client Name_____ Birthdate_____

Assignment of health plan / insurance benefits

I authorize payment of health plan / insurance benefits directly to Peter J. Somers, Ph.D.

_____ _____

Signature of Client or authorized party Date

Release of information

I authorize the release of any health care or other information necessary to process insurance claims.

_____ _____

Signature of Client or authorized party Date

Consent to treatment / Confidentiality of information

I hereby give consent for_____(Client) to receive psychological services. I understand that services to be provided may include assessment, observation, diagnosis, psychotherapy, consultation, and/or crisis intervention.

As with all health care services and procedures, there are some risks associated with psychological services. These risks may include psychological discomfort and possible unexpected effects of treatment. While positive outcomes and behavioral changes are expected, they cannot be guaranteed.

I understand that information will be confidential and will not be shared unless requested and authorized specifically and in writing. There may be exceptions under some unusual circumstances where there are legal requirements for release of information.

_____ _____

Signature of Client or authorized party Date

Financial responsibility

I accept full financial responsibility for services not covered by policy benefits, claims denied due to failures to disclose information regarding insurance coverage or previous mental health services (which may have used allowed benefits), or undisclosed requirements for obtaining prior authorization for these services.

I have received and read the *Client Information* form. I understand that a charge of $25.00 may be made for scheduled appointments which are failed or not cancelled at least 24 hours in advance.

_____ _____

Signature of Client or authorized party Date