155 North Craig Street, Suite 170
Pittsburgh, PA 15213
Appointments – 412-687-8700, Ext. 104

8500 Brooktree Road, Suite 200
Wexford, PA 15090
Business Office – 412-687-9099

NAME: _________________________________ DOB: _____/_____/__________ AGE: _____ SS #_____ - ____ - ________

SEX: ___ M ___ F MARITAL STATUS: ___ SINGLE ___ MARRIED ___ WIDOWED ___ DIVORCED/SEPARATED

ADDRESS: ____

STREET APT # CITY STATE ZIP CODE

HOME PHONE: (_____) _____ - ______ WORK PHONE: (_____) _____ - ______ CELL PHONE: (_____) _____ - ______

EMAIL ADDRESS: ____

EMPLOYER NAME AND ADDRESS: ____

EMERGENCY CONTACT: _____________________________________ PHONE: (______) ______ - __________

RELATIONSHIP TO PATIENT: ____ SPOUSE ____ PARENT ____ GRANDPARENT _____ OTHER: _________

RESPONSIBLE PARTY: ____ RP PHONE: (_____) _____ - ___________

RELATIONSHIP TO PATIENT: _________________________ RP SS#: ____ - ___ - _______ RP DOB: ____/____/_______

RP ADDRESS: ____

RP EMPLOYER: ____ RP WORK PHONE: (_____) _____ - ___________

Which therapist are you seeing today? ____

INSURANCE COVERAGE

____ MEDICARE PART B: HIC # _______________________________ PRIMARY: ____ Y ____ N

____ HIGHMARK BC/BS: ID # ______________________________________ GROUP # ___________________________

Select blue____ Preferred Blue____ Keystone ____ Direct _____ Community ____ Other _______________

____ UPMC HEALTHPLAN: ID # ________________________________ GROUP # ________________________________

Employer: ____ Effective Date ____/____/_______

____ COMMERCIAL INSURANCE CO: NAME ______________________________ PHONE: (_____) _____ - ___________

CLAIM OFFICE ADDRESS: ____

STREET CITY STATE ZIP CODE

ID # ____ GROUP # __________________________________

PLEASE TURN OVER

—PLEASE COMPLETE ALL QUESTIONS—

	YES	NO
Briefly state the problems for which you are seeking care:		
Are you currently under another professional's care for psychotherapy?	☐	☐
Have you had psychotherapy in the past?	☐	☐
If yes, when and with whom? _________________________________		
Referral sources appreciate acknowledgement.		
Do we have permission to thank referral?	☐	☐
Referral source: _______________________________________		
Address (if available): __________________________________		
Or Phone: ____		

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I authorize payment of medical benefits to Cognitive Dynamic Therapy Associates, Inc. or any of its representatives on my behalf for services furnished to me by any member of their group practice. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by an insurance carrier. By signing below, I hereby authorize said assignee to release any information necessary to secure payment.

CONSENT FOR TREATMENT

I consent to psychological evaluation and treatment by the psychotherapists and employees of Cognitive Dynamic Therapy Associates. I understand and accept the CDTA policies. I understand that I may discuss my treatment with my therapist and may withdraw my consent if I so desire. I further understand that no guarantees have been made to me about the outcome of this care.

My signature indicates that I have reviewed and truthfully responded to the information requested on this form. I have read and understand the above assignment of benefits and consent for treatment. I agree to adhere to them until further written notice.

Patient/Guardian Signature: ____ **Date:** _____/_____/_________

—**NOTE: YOUR SIGNATURE REQUIRED**—

Cancellation Policy

We ask that you provide at least 48 hours notice if you need to cancel an appointment.

When you fail to appear for an appointment, or when you cancel at the last minute, it deprives us of the chance to provide service for someone else.

We will bill you for sessions cancelled less than 48 hours in advance, and for missed appointments.

Please note that we cannot bill your insurance for this. The entire cost will be charged to you.

A therapist may waive this fee under certain circumstances, such as severe illness or other unavoidable conditions, but we ask that you respect this policy and provide at least 48 hours notice when you cancel your appointment.

I understand and agree to the terms and conditions of this cancellation policy.

____ ___________________________

Signature Date

Authorization to Disclose Information
To Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I ____________________________, hereby authorize _________________________________
(Please print patient's name) (*Please print treating clinician's name)*

Please check one:

_________ To release any applicable information to my Primary Care Physician

_________ To release medication information only to my Primary Care Physician

_________ Not to release information to my Primary Care Physician

______________________________________ _____________________
(*Patient's or Patient's Guardian, please sign*) (*Date*)

______________________________________ _____________________
(*Please print the name singed above*) *(Birth Date*)

Primary Care Physician's Name, Address, and Phone Number:

____

____

____

____

Note to Behavioral Health Care Provider:
Please Maintain Original Copy in Patient's File

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on the use and disclosure of their protected health information (PHI). Individuals are also given the right to request confidential communications or that PHI be communicated in an alternative manner, such as sending correspondence to the person's office instead of the person's home.
Please indicate any restrictions on how and where the staff of CDTA might contact you:
____

The privacy rule also requires health care providers to take reasonable steps to limit the use of or disclosure of PHI. These provisions do not apply to specific uses or disclosures made pursuant to the individual's request.

Health care entities must keep records of PHI disclosures. The information recorded below will constitute such a record. (Note that issues and disclosures of information for treatment records, payment information, and healthcare operations are permitted without prior consent in an emergency.)

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom (Address or fax #)	Description and Purpose of Disclosure	By Whom Disclosed	Initials

By signing below I confirm that I have read and understand the HIPPA policy outlined above.

____ _________________

(*Patient Signature)* (*Date*)

____ _________________

(*Print Name*) (*Date of Birth*)

Cognitive Dynamic Therapy Associates
155 North Craig Street, Suite 170, Pittsburgh, PA 15213
412-687-9099 412-687-8700 manager@cogdyn.com
www.cogdyn.com

CDTA Financial Policy

I, ____________________________, understand that I am responsible for any and all charges for services rendered by CDTA, including those not covered by my insurance provider.

Please check one of the following:

_____ My insurance carrier may cover services at CDTA. I will make all co-payments (if applicable) and will be responsible for any remaining balances.

_____ I will pay for services myself.
(**Please Note**: if you choose this option, we cannot retroactively bill your existing insurance)

I will make co-payments:

_____ At time of service.

_____ Other (Special Arrangement): ____
A monthly statement will be sent to your home if payments are not made at the time of service.

I agree to the terms of this notice

____
(*Please Print Responsible Party's Name*)

__________________________________ __________________
(*Please Sign Responsible Party's Name*) (*Date)*

Balance Quest Coaching
155 North Craig Street, Suite 170
Pittsburgh, Pennsylvania 15213
412-687-8700 412-687-9099
manager@cogdyn.com
www.cogdyn.com

CHARGE AUTHORIZATION FORM

CARDHOLDER'S NAME: ____

CLIENT'S NAME: ____

ZIP CODE FOR CARDHOLDER: ____

CREDIT CARD ACCOUNT NUMBER: ____________ - _____________ - ____________ - ____________

EXPIRATION DATE (MM/YY): _________ /_________

SECURITY CODE (BACK OF CARD): ________________ CO-PAY AMOUNT: $ ______________

PRE-ARRANGED PAYMENTS AUTHORIZATION AGREEMENT

I hereby authorize and allow CDTA to charge my credit card account after each office visit for the agreed upon session fee. This authority will remain in effect until I notify CDTA in writing otherwise. If I change the credit card specified, I will provide written authorization for the new credit card to CDTA immediately. In addition, I have the right to stop payment for of a charge by notifying CDTA before the account is charged. I understand that CDTA reserves the right to terminate this payment plan and/or my participation therein.

Signature ____ Date ________________________