SUNPOINTE HEALTH

320 Rolling Ridge Drive, Suite 100, State College, PA 16801 • Phone: (814)867-0670 • Fax: (814)867-7616

Patient Registration

PLEASE USE BLACK PEN

Patient Name: _____ Account #: _____ Today's Date: ____/____/____

Date of Birth: ____/____/____ Age: ____ SS#:_____-_____-_____ Gender: _____ Marital Status: _____

Phone # – Home: (_____)_____-_____ - Work: (_____)_____-_____Ext_____ - Cell: (_____)_____-_____

Please indicate your preferred phone number for automated appointment reminder calls (select one):

☐ Home ☐ Work ☐ Cell ☐ I do not want reminder calls

Billing Address – Street:_____ City: _____ State: _____ Zip: _____

Local Mailing Address - Street:_____ City: _____ State: _____ Zip: _____
(PSU Students)

Race:	**Ethnicity:**	**Preferred Language:**
☐ White	☐ Hispanic/Latino	☐ English
☐ Black/African American	☐ Not Hispanic/Latino	☐ Spanish
☐ Asian	☐ Decline to Answer/Unknown	☐ Mandarin
☐ American Indian/Alaska Native		☐ Hindi
☐ Native Hawaiian/Pacific Islander		☐ Other: _____
☐ Decline to Answer/Unknown		
☐ Other: _____		

Health Insurance Information: (Please complete all sections that apply and be sure to give receptionist copy of all cards)

Primary Health Insurance Plan- Plan Name: _____ Ins. ID #: _____

Policy Holder Information: □ Self - □ Other (Name: _____ SS#: ___-___-____ Birthdate: ____/____/____)

Secondary Health Insurance Plan- Plan Name: _____ Ins. ID #: _____

Policy Holder Information: □ Self - □ Other (Name: _____ SS#: ___-___-____ Birthdate: ____/____/____)

******I certify that I □ **am** or □ **am not** covered by Medical Assistance Insurance (ie: CCBH, CBHNP, the Access Card, etc.).**
Signature of Patient (or Parent/Guardian if under age 14): _____ Date: ____/____/____

If you have indicated that you are covered by Medical Assistance, please be sure that coverage information is noted on this page.

Prescription Insurance Coverage/Medicare Part D – Name of Plan: _____ ID #:_____

EAP - Name of Employee Assistance Program: _____ Authorization #: _____

Assignment of Benefits: I hereby request that payment of authorized Medicare, Medicaid, and all other insurance benefits be made on my behalf to SunPointe Health for any services provided to me (or my child/my ward). I authorize any holder of my (or my child's/my ward's) medical record information to release information to the appropriate entity and its agents in order to determine these benefits payable for related services.

Signature of Patient (or Parent/Guardian if under age 14):_____ **Date: ____/____/____**

Account #: _____

SUNPOINTE HEALTH

Consent for Treatment:

I, _____, agree to allow clinicians at SunPointe Health to provide me with behavioral health care. I understand that in addition to my primary provider(s), other clinicians from this practice may be involved in my care in order to provide coverage in my clinician's absence.

Signature of Patient (or Parent/Guardian if under age 14):_____ **Date: ____/____/____**

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of SunPointe Health's Notice of Privacy Practices and Patient Handbook.

Signature of Patient (or Parent/Guardian if under age 14):_____ **Date: ____/____/____**

Consent for Use and Disclosure of Protected Health Information:

Identifiable healthcare information about you (Protected Health Information) may be used or disclosed to carry out treatment, payment, or healthcare operations. The terms of this notice may change and you may request a revised notice in person, by phone, in writing, or at our website at www.forabrighterfuture.com. Changes are made from time to time to comply with state and federal law and professional ethical guidelines.

- You have the right to request restrictions in the use or disclosure of your Protected Health Information. Your clinician(s) at SunPointe Health are not required to agree to the requested restrictions if these are not seen as being in your best interest, but are required to explain their reasons to you. Once agreed to, any requested restrictions must be honored.
- You may revoke your consent to release this information at any time by providing this request in writing to your clinician or the Health Information Management department. Changing this consent will not apply to uses and disclosures that have already occurred.
- If you are treated by a member(s) of **Susquehanna Valley Professional Associates**, your Protected Health Information may be shared within this group, as necessary, for coordination of care, coverage in your clinician's absence, and consultation. The SVPA group includes all clinicians except: Laura Dell'Olio, LCSW, Richard Plut, PhD, Sandra Craig, LCSW, Craig Walters, LCSW, Barbara Ziff, LCSW, and Jerry Boyer, MA.

I, _____, authorize the use and disclosure of my (or my child/my wards) medical record information, which may include mental/behavioral health, HIV/Aids, sexually transmitted disease, and/or drug and alcohol abuse/dependence, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, for the purpose of treatment, payment, or healthcare operations within the limits described in the Notice of Health Information Privacy Practice. **This consent is required for your participation in treatment.**

Signature of Patient (or Parent/Guardian if under age 14):_____ **Date: ____/____/____**

Account #: _____

SUNPOINTE HEALTH

Primary Care Provider

Name and Address of Primary Care Provider**:** _____

_____

_____

Phone: (_____)_____-_____

Fax: (_____)_____-_____

Emergency Contact Information

Name: _____ Relationship to Patient: _____

Phone Numbers – Home: (____)_____-_____ Work: (____)_____-_____x ____ Cell: (____)_____-_____

Release for Patient Appointment/Financial Information

By signing below, I authorize the providers and staff of SunPointe Health to release information regarding my appointment dates and times and/or financial information with the person(s) listed below. I understand that by signing this release, and checking the applicable box(es) the designated person(s) will 1) be able to speak to any member of SunPointe Health regarding my appointments and may schedule or change appointments on my behalf and/or 2) be able to speak to staff regarding my account balance and billing information. **This authorization pertains only to appointment and/or financial information.** In order to release any further information to the person(s) named below, a full release of information must be completed. If at any time you wish to revoke this release, you must provide written notification to our office.

		Appointment	Financial
Name: _____	Relationship:_____	☐	☐
Name: _____	Relationship:_____	☐	☐
Name: _____	Relationship:_____	☐	☐
Name: _____	Relationship:_____	☐	☐

Signature of Patient (or Parent/Guardian if under age 14):_____ **Date: ____/____/____**

Account #: _____

SUNPOINTE HEALTH

Financial Policy

Guarantee of Payment: I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to SunPointe Health are not paid according to this financial policy, the account will be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fees. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

- **I agree to provide all information required by SunPointe Health and my insurance company for billing purposes. I understand that if this information is not provided in a timely manner, I may be responsible for any amounts denied by my insurance company, and SunPointe Health has the right to pursue termination of treatment.**

- **I agree to provide SunPointe Health with a valid credit card number to be used for each appointment and for any patient amount due. Appointments will be scheduled only after payment in full is received. (Specific Credit Card on File policies are outlined on the Credit Card Authorization on the next page.)**

- **I agree to pay the following fees, if applicable:**
  - Returned Check Fee- $40
  - No-Show Fee- $70
  - Late Cancellation Fee- $45 (If less than 24 hours)
  - After hour's crisis/urgent calls to your clinician or clinician on call (cost depends on length of call and needed intervention.)

- **I understand that it is my responsibility to verify my insurance benefits. Any quote of benefits obtained by SunPointe Health is provided as a courtesy by our billing department. We do our best to obtain accurate information, but we cannot guarantee that claims will process according to quoted benefits.**

- **If at any time, I am unable to pay my balance in full, I agree to contact the patient accounting department to establish a repayment agreement.** SunPointe Health reserves the right to pursue termination of treatment for financially delinquent accounts. (Those that are not receiving regular monthly payments on existing balances.) **(Patient Accounting Direct line: 814-272-3121)**

Printed Name of Guarantor (Must be 18 or Older): _____**Guarantor Signature**:_____

Printed Name of Patient (if different than Guarantor):_____ **Date: ____/____/____**

*****No person under the age of 18 may sign under Guarantee of Payment.*****

Guarantor Information (if person other than patient):

Relationship to Patient: _____ **Phone #**:_____ **D.O.B**: **____/____/____** **SSN:**_____

Address - Street:_____ City: _____ State: _____ Zip: _____

Signature of Witness:_____ **Date: ____/____/____**

Account #: _____

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Credit Card Authorization

If you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card at the time you check in and the information will be held securely. You will always have the option to pay fees using another payment method, if you do so in a timely manner. Charges to the credit card will be determined in the following manner:

Copays/Self Pay Charges – Copays are due on the date of service, per your contract with your insurance company. Self-pay charges are due on the date of service, per your agreement with our office. You may present another method of payment prior to, or at the time of service. ***If another method of payment is not offered by the date of service, your credit card will be charged.***

Co-Insurances and/or Deductibles – These amounts are determined after your insurance company has completed processing your claim. At that time, if a balance remains on your account, a statement will be sent. You will have 45 days to make a payment on the account using another method of payment. ***If, at 45 days, no payment has been received, your credit card will be charged for any balance over 45 days old.***

Psychological Testing/TMS – Insurance benefits for psychological, neuropsychological testing or TMS are often different than the benefits that would apply for other visits to our office. For this reason, we will require a credit card on file if you are scheduled for any of these treatments. If a balance remains on your account after your insurance company has processed your claim, a statement will be sent. You will have 45 days to make a payment on the account using another method of payment. ***If, at 45 days, no payment has been received, your credit card will be charged for any balance over 45 days old.*** .

Late Cancelation or No Show Charges – These charges are generated by your provider if you fail to show up for a scheduled appointment, or if you do not give adequate notice (24 hours) for canceling an appointment. If you incur such a charge, a statement will be sent. You will have 45 days to make a payment on the account using another method of payment. ***If, at 45 days, no payment has been received, your credit card will be charged for any balance over 45 days old.***

Our Credit Card on File Program is intended as both an advantage to you and to our office. You will no longer have to write out and mail us checks, and in turn, it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down. This will not compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment method, do not hesitate to ask.

****PLEASE NOTE:** If the Credit Card provided expires, becomes invalid, or lacks sufficient funds, it will be required that you update your Credit Card on File information and/or pay your balance in full in order to reschedule with your provider.

Authorization to Charge my Credit Card

Until further notice, I authorize SunPointe Health to charge patient balances on this account to the following credit card:

Patient Name (printed): _____ Patient Date of Birth: ____/_____/____

Card Type (circle one): Visa MasterCard Discover

Name on Card: _____ Card Holder Signature: _____ Date: ____/_____/____

Credit Card Number: _____-_____-_____-_____ Exp. Date (mm/my):_____/_____ Billing Zip Code: _____

Email address for receipts (please write legibly): _____

****DO NOT PROVIDE A FLEX/HSA/HRA CARD AS YOUR CREDIT CARD ON FILE. WE WILL NOT BE HELD RESPONSIBLE FOR DETERMINING ELIGIBLE CHARGES ON THOSE TYPES OF ACCOUNTS. ****