New Patient Registration Form

James P. McHugh, Ph.D.

Welcome To My Practice. Please complete the following information form:

Patient: _____ ❑ Male ❑ Female
Last First M I

Address: _____
Street City State Zip

Home Ph: _____ Work Ph: _____ Cell: _____

Birth Date: ____/____/_____ Age: _____ SSN: _____ _____ _____

Marital Status: ❑ Single ❑ Married ❑ Legally Separated ❑ Divorced ❑ Widowed

E-Mail: _____

Employment Status: ❑ Not Employed ❑ Full Time ❑ Part Time ❑ Retired

Employer:_____

Student Status: ❑ Non Student ❑ Full time ❑ Pt time

Person to be Notified
In Case of Emergency: _____

Home Ph: _____ Work Ph: _____ Cell:_____

Primary Insurance Information:

Insurance Company: _____ Phone: _____
Provider number on back of card

ID#: _____ Group# _____

Name of Primary Insured (if other than you): _____

Patient's Relationship to Guarantor: ❑ Spouse ❑ Child ❑ Stepchild ❑ Other

Address: _____
Street City State

Home Ph: _____ Work Ph: _____ Cell: _____

Birth Date: ____/____/_____ Employer: _____

Secondary Insurance Information:

Insurance Company: _____ Phone: _____
Provider number on back of card

ID#: _____ Group#:_____

Name of Primary Insured (if other than you): _____

Patient's Relationship to Guarantor: ❑ Spouse ❑ Child ❑ Stepchild ❑ Other

Address: _____
Street City State Zip

Home Ph: _____ Work Ph: _____ Cell: _____

Birth Date: ____/____/____ Employer: _____

If you were referred by a physician, it is our practice to send a letter to the referring physicians and/or to your primary care physicians at the outset of therapy. Typically this letter reviews the history of your illness as you have described it, symptoms, diagnosis and initial treatment plan. However, this is NOT a condition of treatment with Dr. McHugh, and if you opt not to have this letter sent, it will not affect the provision of treatment. Do you want your physician notified that you (or your child) are receiving treatment? ❑ Yes ❑ No

Physician _____ Phone: _____

Address: _____
Street City State

_____ _____
Patient's Signature Date

_____
Signature of Parent or Guardian

Please Continue on Next Page!

Permissions and Releases

Please read the following carefully!

1. If I opt to submit a claim to my insurance company for services rendered, I hereby authorize Dr. James McHugh to release all information necessary for the filing of claims to my insurance company or companies, via paper documents, an electronic relay service or a billing service. Such information typically includes dates of service and diagnosis, but when requested by the insurance company, may also include symptoms, illness history, treatment plan, prognosis and other information required by the insurance company to process claims. I further expressly agree and acknowledge that my signature on this document authorizes James P. McHugh, Ph.D. to submit to my insurance company claims for benefits for all testing, treatment and/or other services provided to me and/or my dependents, without obtaining my signature on each and every claim, and I will be bound by this signature as though I had personally signed each claim.

   Furthermore, I authorize my Insurance Company or Companies to pay Dr. James McHugh directly, and hereby assign to Dr. James McHugh all benefits, if any, otherwise payable to me for his/her psychological services. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, received by or paid to James P. McHugh, Ph.D., will be credited to my account, in accordance with the above said agreement.

2. I have been given access to the "Consent to Treatment" document, and to the "Notice of Policies and Practices to Protect the Privacy of Your Health Information" document. I understand that I can view these documents anytime on Dr. McHugh's web site, or I can obtain a paper copy of either or both documents upon request.

   My signature on this page indicates that I have read and understand, accept and will abide by the terms and conditions of both documents. I agree that I will hold Dr. McHugh harmless for execution of his responsibilities under these aforementioned documents. Unless I notify Dr. James McHugh otherwise in writing, my continued participation in therapy is acknowledgement that I accept the terms and conditions of these documents and continue to agree to abide by these documents.

3. In accordance with the above, I hereby give my consent for Dr. McHugh to obtain from me clinical information, such as symptoms, history, personal and family information, etc., and to use this information to diagnose and provide treatment for me. I understand that this information is maintained in my patient chart, either electronically or physically, and is kept in Dr. McHugh's office or otherwise in his custody under secure conditions. I agree that after my treatment has been concluded, my records may be transferred to an offsite secure storage location.

4. I consent to have billing statements sent to me by mail, and to be contacted by phone, text message, or e-mail to remind me of appointments or to discuss payment. I further consent to having messages left on my answering service or speaking with family members regarding these matters.

5. If I have so indicated on the New Patient Registration form, I authorize Dr. McHugh to notify my physician(s) of my treatment with Dr. McHugh. Such authorization may include my symptoms, diagnosis and response to treatment. It is standard practice to send a letter to referring physicians and/or to primary care physicians at the outset of therapy, but I understand that this is not a condition of my treatment with Dr. McHugh. This authorization will remain in effect for as long as I continue in treatment with Dr. McHugh, and for two months following termination of treatment. However, I understand that I can I can revoke this authorization at any time by notifying Dr. McHugh in writing of my desire to revoke.

6. As stated in the Consent to Treatment document, I accept responsibility for canceling appointments in a timely manner, and agree to the condition that ***if I fail to cancel an appointment at least one business day prior to an appointment, I will be charged a $55.00 late cancellation fee.*** This fee will be waived, at Dr. McHugh's discretion, if I am unable to attend a session due to circumstances beyond my control, such as illness or a death in the family.

_____ _____

Patient Date

_____

Patient's Parent or Guardian

_____

Witness