**DR. WANDA EPPES AND ASSOCIATES**
**PATIENT REGISTRATION FORM**

NAME______________________________________________ PHONE __________________
Last First Middle
PARENT/CLIENT EMAIL__________________________________________________________

HOME ADDRESS ______________________________________________________________
Number & Street City State Zip
BIRTHDATE ______________________ GENDER _______ CELL PHONE __________________

REASON FOR REFERRAL ________________________________________________________

REFERRED BY ____________ PREVIOUS COUNSELOR OR PSYCHOLOGIST _______________
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PAYMENT IS CONSIDERED DUE WHEN SERVICES ARE RENDERED we do not accept insurance

_________________________________________________________________________________
Insurance Company Name Address City State Zip Phone

_________________________________________________________________________________
Subscriber's Name Policy Number Group Name
I hereby authorize said assignee to release all information necessary to facilitate reimbursement to insured. I understand that I am financially responsible for all charges and that the insurance company should reimburse me (the insured).
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**TO BE FILLED OUT IF THE CLIENT IS A MINOR CHILD**

CHILD LIVES WITH: Both Parents ______, Mother ______, Father _____, Other_____________ (name)

**FATHER'S NAME** __________________________ EMPLOYER____________________________

HOME ADDRESS ______________________________________________________________

HOME PHONE ______________ WORK PHONE _____________ CELL PHONE ______________

**MOTHER'S NAME** __________________________ EMPLOYER____________________________

HOME ADDRESS ______________________________________________________________

HOME PHONE ______________ WORK PHONE ____________ CELL PHONE ______________

CHILD'S DOCTOR ____________________________________________________________
I am the above named minor child's natural parent or legal guardian.

_________________________________________________________________________________
SIGNATURE DATE
**IMPORTANT: READ AND SIGN OFFICE POLICY STATEMENT ON THE REVERSE OF THIS PAGE and PLEASE EMAIL/FAX TO 888-366-4008 TO SECURE YOUR APPOINTMENT.**

**DR. WANDA EPPES & ASSOCIATES**

**PSYCHOLOGISTS:** WANDA EPPES, PSY. D., PY4960, SS178
**SCHOOL PSYCHOLOGISTS:** Mary Travis, PhD. SS672 Natacha Noel, Ed.S., SS1174
Mikerlande Gedeum, Ed.S. SS1603 Amanda Hill, Ed.S. SS1563 Dashana Lane, Ed.D., FL SS 1874
Sara Sanders, M.S. Ed, C.A.S, SS1362 Susan Valero, M.S. Ed., P.D., SS1219

Welcome to our office. We are pleased to have you as a potential patient of our practice. Our professional experience has shown us that an up-front understanding of office policies regarding payment for services, confidentiality and cancellation reduces misunderstanding and makes for a smoother therapeutic process. Please feel free to request clarification concerning these policies at any time or to ask us about our educational backgrounds, training or areas of expertise.

Regarding payment for services, our policy is that payment is due when service is rendered. As a courtesy, we will provide an invoice for you to file with your insurance company so that you can be reimbursed, if allowed. We must emphasize that as mental health providers, our relationship is with you, not your insurance company; therefore you are financially responsible for all charges whether or not reimbursed by insurance.

**POLICY REGARDING CONFIDENTIALITY AND INFORMED CONSENT**

Confidentiality of records or information collected about you will be held or released in strict accordance with state laws regarding confidentiality of such records and information. Confidentiality of your records may be breached only under the following circumstances: if you sign a release of your records, if there is a clear and immediate probability that you will seriously harm yourself or others, and/or if there is evidence or strong suspicion of child or elder abuse. Be advised that the reception room is under video surveillance.

**POLICY REGARDING CANCELLATION OF APPOINTMENTS**

We request that you give at least a 24 hour notice of cancellation for any appointment. We have a 24 hour answering service with which you can leave your full message regarding cancellation. (407) 677-4001 or back line 407-414-8751, and (719) 839-0820 cell. We do not text. You will be charged the usual and customary fee for missed appointments or sessions canceled with less than a 24-hour notice unless there was a clear emergency or urgent reason why you were not able to attend or give sufficient notice. We require a $100.00 security deposit to hold your appointment and need 7 days or more notice for cancellation or the deposit is not refunded. If you choose to reschedule within 60 days, your deposit will be assigned to the new appointment times. There is a $25 administrative fee assessed against the deposit for any cancellation or reschedule. If, after you receive your report you wish more copies, there will be a $25 charge for new copies in pdf form. If you need duplicate records in the future or if you need a new document created with original signature, it is charged at $200/hour in quarter hour increments, minimum $50. If the quoted amount of time for testing is insufficient, additional time is billed at $200/hour in quarter-hour increments. If you wish an additional one-hour feedback/consultation session, it is billed at $200/hour. Phone consultation over 10 minutes is also billed at $200/hour in quarter hour increments.

**FINANCIAL RELEASE**

My signature below indicates that I have read and understood the above policies. It also allows release of financial records to communicate with an attorney and/or collections agency if payment is 90 days or more delinquent. Any charges incurred in the collections effort will be charged to my account and will be my responsibility.

Printed Name ____________________ Relationship to client ____________________

Signature ____________________ Date ____________________