Shelley Sandbulte, 2210 W Brown Place, Sioux Falls, 57105 (605) 332-1700

- **CLIENT INFORMATION**

Social Security # ________________________ Date ________________________

Name ________________________ DOB ____________ AGE ________

Address ________________________ Home Phone ________________________
Street/Box #

________________________ Cell Phone ________________________
City State/Zip

Employment ________________________ Work Phone ________________________

- **Please note which number we can call to confirm or change appointments** ____________

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐

- **FAMILY INFORMATION**

Social Security # ________________________ DOB ____________ AGE ____________

Parent/Spouse/Partner Name ____

Address ________________________ Home Phone ________________________
Street/Box

________________________ Cell Phone ________________________
City State/Zip

Employment ________________________ Work Phone ________________________

- **CHILDREN**

NAME	DOB	AGE	LIVING AT HOME

- Primary Physician: ____

- List any medications your are taking and/or any allergies you may have: ________________________
____
____

- Who referred you to our office? ____

- **CONSULTATION**

I give permission for my therapist to consult with my physician and/or referral source.

________________________ ________________________
Signature Date

Your signature below indicates your written permission allowing me to consult with other qualified therapists as needed.

________________________ ________________________
Signature Date

PLEASE COMPLETE BOTH PAGES

- Other Information:

____

- **FEES AND INSURANCE**
  - **Initial Assessment & Consultation** **$150.00**
  - **Individual Therapy, 50 Minute Session** **$115.00**
  - **Pre-Gastric Bypass Evaluation** **$200.00**
  - **Psychological Testing** **$300.00**

Payment of fees is the client's responsibility. You may be charged for failure to appear for your scheduled appointments and/or phone calls of substance. (**Appointments not cancelled 24 hours in advance are considered failed appointments, and you may be charged for them)** Insurance does not cover this.

We will submit an insurance claim for you if you wish. Shelley Sandbulte does not accept responsibility for collecting insurance claims or negotiating a settlement in a disputed claim. The professional services performed at this office are charged to you, not to your insurance company. Therefore, if there is a problem in payment by your insurance company, you will be responsible for prompt payment. If we file a claim for you, we will require you to authorize your insurance company to make payment directly to Mary Eggleston unless you pay in full for each session as services are rendered.

AT MINIMUM, SHELLEY SANDBULTE EXPECTS THAT THE CLIENT WILL MAKE CO-PAYMENT (estimated percentage of the fee that insurance will not cover) **AFTER EACH SESSION,** unless alternative arrangements are made with your therapist. Should you wish to discuss fees or charges, you are encouraged to ask your therapist about this. It will be your advantage to make payment promptly as a 1.0 % (12% per year) finance charge may be assessed on all balances 60 or more days past due, regardless of pending insurance payments.

I have read and understand fee and insurance information. Fees associated with therapy will be paid by:

____________________ ____________________

Signature **Date**

- **INSURANCE INFORMATION**

Name of Insured ____________________ Insured's DOB ____________________

Carrier ____________________ ID Number ____________________

Address ____________________ Group/Account # ____________________

____________________ Co-Pay $ ____________________

Deductible $ ____________________ Deductible met? ____________________

I understand that it is my responsibility to contact my insurance company on pre-authorization procedures.

____________________ ____________________

Signature Date

I hereby authorize Shelley Sandbulte to furnish information to insurance carriers concerning my treatments and hereby assign to the therapist all payments for medical services rendered to myself and my dependents.

<u>I understand that I am responsible for any amount not covered by insurance.</u>

____________________ ____________________

Signature Date