DOCTOR OR THERAPIST TO BE SEEN (PLEASE CHECK ONE)

[] JOHN C BURNSIDE, MD [] GARY M BARNARD, PHD [] KRISTEEN R SPRATLEY, MD [] NANCY H PETERSON, MS

PATIENT REFERRED BY: ______________________

PATIENT INFORMATION

NAME: ______________________ SEX: [] M [] F

ADDRESS: ______________________ BIRTHDATE: __________

CITY__________ STATE__________ ZIP__________ AGE: __________

HOME PHONE: (   ) __________ WORK PHONE: (   ) __________

SOCIAL SECURITY #: __________ MARITAL STATUS: [] S [] M [] D [] W

SCHOOL/EMPLOYER: __________ GRADE/POSITION: __________

RESPONSIBLE PARTY INFORMATION

NAME: ______________________ SEX: [] M [] F

ADDRESS: ______________________ BIRTHDATE: __________

CITY__________ STATE__________ ZIP__________ AGE: __________

HOME PHONE: (   ) __________ WORK PHONE: (   ) __________

SOCIAL SECURITY #: __________ MARITAL STATUS: [] S [] M [] D [] W

EMPLOYER: __________ POSITION: __________

IF YOU WOULD LIKE US TO FILE YOUR INSURANCE FOR YOUR REIMBURSMENT FILL OUT BELOW AND PRESENT INSURANCE CARD.

INSURED INFORMATION

NAME: ______________________ SEX: [] M [] F

ADDRESS: ______________________ BIRTHDATE: __________

CITY__________ STATE__________ ZIP__________ AGE: __________

HOME PHONE: (   ) __________ WORK PHONE: (   ) __________

SOCIAL SECURITY #: __________ MARITAL STATUS: [] S [] M [] D [] W

EMPLOYER: __________ POSITION: __________

TERMS OF PAYMENT AGREEMENT
FOR ALL PROVIDERS

WELCOME TO THE ADHD CLINIC. WE ARE GLAD YOU ARE HERE.

BELOW YOU WILL FIND OUR POLICY REGARDING PAYMENT FOR SERVICES RENDERED. SHOULD YOU HAVE ANY QUESTIONS, PLEASE DON'T HESITATE TO ASK AT THE FRONT DESK. WE WILL BE HAPPY TO ASSIST YOU.

- **PAYMENT FOR SERVICES ARE EXPECTED IN FULL AT TIME OF SERVICE**, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH THE DOCTOR.
- **OFFICE HOURS**: Monday - Thursday 9:00-11:30 and 1:00-6:00

  The doctors are not in the office on Fridays,
- **PRESCRIPTIONS** : Call in 24 hours in advance
- **CANCELLATIONS**: Please give at least ***24-hour notice*** when canceling an appointment. Late cancellations are billed at full office visit fee.
- **"NO SHOW" APPOINTMENTS**: Will be billed at full office visit fee.
- **PHONE CONFERENCE**: These appointments are guaranteed with a credit card or paid for before booking the appointment.
- **CONFIDENTIALITY**: Information from this form or disclosed in a session is considered confidential and will not be shared with any individual or agency without written consent of the client(s), except as noted in the paragraph below.
- **LEGAL OBLIGATION**: I am legally obligated to warn of imminent danger. Circumstances, which overrides professional confidentiality, include, but are not limited to, actual or suspected physical or sexual abuse of a minor or elder, actual or suspected suicide or homicide, and cases where a legal subpoena is involved.
- **INSURANCE**: Please request an insurance receipt if you will be filing claims. If your insurance can be filed electronically our office can assist you.

**********FINANCIAL AGREEMENT**********

I HAVE READ AND UNDERSTAND THE "TERMS OF PAYMENT AGREEMENT" ABOVE AND ASSUME FINANCIAL RESPONSIBILITY FOR MY TOTAL BILL AND GIVE VOLUNTARY CONSENT TO RECEIVE TREATMENT.

____________ TODAY'S DATE

______________________________ PATIENT'S NAME (IF PATIENT IS A MINOR)

______________________________ GUARDIAN/RESPONSIBLE PARTY SIGNATURE