

SALLY G HOYLE, PHD
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724.272.2124

NAME: _____ DOB: ____/____/____ AGE: ____ SS# ____/____/____

SEX: __M__F MARITAL STATUS: __SINGLE__MARRIED__WIDOWED__DIVORCED/SEPARATED

ADDRESS _____
STREET APT# CITY STATE ZIP

HOME PHONE: (____) ____ - ____ WORK PHONE: (____) ____ - ____ CELL/PAGER: (____) ____ - ____

E-MAIL ADDRESS: _____ SIGN-UP FOR E-NEWSLETTER? __YES__NO

EMPLOYER NAME AND ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: (____) ____ - ____

RELATIONSHIP TO PATIENT: __SPOUSE__PARENT__GRANDPARENT__OTHER: _____

RESPONSIBLE PARTY: _____ RP PHONE: (____) ____ - ____

RELATIONSHIP TO PATIENT: _____ RP SS# ____/____/____ RP DOB: ____/____/____

RP ADDRESS _____

RP EMPLOYER: _____ RP WORK PHONE: (____) ____ - ____

Which provider are you seeing today? _____

INSURANCE COVERAGE

__SELF PAY/NO INSURANCE COVERAGE__ __SELF PAY/WILL NOT USE INSURANCE__

__MEDICARE PART B: HIC # _____ EFFECTIVE DATE: ____/____/____ PRIMARY __Y__N

__HIGHMARK BC/BS: ID# _____ GROUP # _____

__COMM BLUE__ __SELECT BLUE__ __PREFERRED BLUE__ __DIRECT BLUE__ __COMP__ __KEYSTONE__ __BS65

__UPMC HEALTH PLAN: ID# _____ GROUP # _____

EMPLOYER: _____ EFFECTIVE DATE: ____/____/____

__OTHER INSURANCE CO: _____ PHONE: (____) ____ - ____

CLAIM OFFICE ADDRESS: _____

ID# _____ GROUP # _____

--- PLEASE TURN OVER ---

NOTE: SIGNATURE REQUIRED BELOW

CANCELLATION POLICY

Your appointment time is reserved each week especially for you in order to ensure continuity of treatment. Cancellations and missed appointments invariably disrupt the therapeutic momentum and diminish the effect of therapy. Your therapist will make every effort to avoid disruptions in scheduling, and in unavoidable cases such as illness, offer you the chance to reschedule. Adherence to the schedule established by you and your therapist is, therefore, a goal shared by client and clinician in order to optimize your treatment.

Since it is typically not possible for your therapist to fill a session cancelled less than 48 hours in advance, a missed session or late cancellation will be charged even though it was not attended. Please note that although insurance companies will not pay for missed sessions, you will still be held responsible for the full amount. In case of serious unavoidable circumstances, your therapist will use his or her discretion regarding the charge. It is our experience that most sessions are regularly attended and that charges for cancellations are rarely required.

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby assign payment of authorized Medicare, Medical Assistance, and/or any other medical and/or psychotherapy benefits, to include major medical benefits to which I am entitled, to be made to Sally G. Hoyle, PhD or any representatives on my behalf for services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. By signing below, I hereby authorize said assignee to release any information necessary to secure payment.

CONSENT FOR TREATMENT

I _____ consent to psychological evaluation and treatment by Sally G. Hoyle, PhD. I have received and read the policies as outlined in the Office Policy Brochure. The guidelines as delineated are understood and accepted by me. I understand that I may discuss treatment with my therapist and may withdraw my consent if I so desire. I further understand that no guarantees have been made to me about the outcome of this care.

My signature indicates that I have read and understood these policies, and agree to adhere to them until further written notice.

Patient/Guardian Signature: _____ **Date:** ____/____/____