New Client Registration

Name *(Last, First, M.I.):*	**DOB:**

Insurance Information

Insurance Company:	**Member ID:**
Group #:	**Plan Code:**
Please submit a copy of the front and back of your insurance card with your completed paperwork.	

Financially Responsible Party (Write "Self" if it is you.)

Name *(Last, First, M.I.):*			**DOB:**
Relationship to client:	**SS Number:**		
Street address:	**City:**	**State:**	**Zip:**
Home phone:	**Work phone:**		
Employer:	**Occupation:**		

Brief Description of Concerns & Goals

Client Acknowledgements/Consents

1. I agree to be evaluated by Erin Bowman, PhD, HSPP. Following the evaluation, I will be asked to consent to specific treatment recommendations as stated in the treatment plan.
2. I understand these services are voluntary and that I may revoke consent at any time.
3. I have received a copy of my Rights and Responsibilities in regard to services being provided. Dr. Bowman has reviewed and explained these rights to me and, when appropriate, to my family/advocate/ representative.
4. I have received a copy of Dr. Bowman's Notice of Privacy Practices.

I acknowledge that the above statements and information have been explained and reviewed with me, and I understand the statements. My signature below indicates that the results of the assessment, treatment recommendation and proposed interventions have been explained to me. I voluntarily consent to participate in this plan of care. I am aware that similar services are available from other provider organizations and agencies. I choose to receive services through Erin Bowman, PhD, LLC.

_____ _____

Client Signature Date

_____ _____

Client's representative signature (if applicable) Representative's Authority

Erin Bowman, PhD, LLC / erinbowmanphd@gmail.com / www.3RiversWell.com
4630 W Jefferson Blvd, Suite 3, Fort Wayne, IN 46804 / P 260-627-4411 / F 260-233-9464

Financial Agreement

I understand that if I choose not to use my insurance benefits ("self pay") or if Dr. Bowman is not a participating provider with my insurance plan ("out of network"), I will pay in full, at the time of service, for all services rendered on my behalf.

I understand that if Dr. Bowman is a participating provider ("In network") I will pay the copay at the time of service & Dr. Bowman will submit a claim to my insurance provider. I hereby give consent to Dr. Bowman to release any required health information to my health care insurance provider to assist in the processing of claims, including protected healthcare information in accordance with the Health Insurance Portability and Accountability Act (HIPPA). I also and acknowledge that I am responsible for any charges not covered by my health insurance.

I understand that 24 hours' notice of cancellation is required to avoid a $50 charge for missed appointments. I also understand that I may be charged a late fee if I arrive more than 15 minutes late to my appointment. I understand that missed appointment fees and late fees are not covered by insurance plans. In the event my account is sent to collections, I agree to pay for all charges incurred, court costs, interest, and reasonable attorney's fees. Your signature indicates that you have read and agree to the financial agreement.

Signature of Financial Responsibility: _____Date: _____

Missed/Canceled Appointments

I understand that my attendance is critical to the therapy process and will have a direct impact on my treatment and progress; therefore I understand the importance of attendance and the likely negative impact of repeated missed/canceled appointments. I also understand that routine cancellations or missed appointments may result in fees, as well as a referral to another agency for ongoing services. In the event that I miss or cancel multiple appointments, I accept that I may be referred to another facility that may be able to accommodate a more irregular therapy schedule.

Signature Consenting to Attendance Policy: _____ Date:_____

Authorization for Messages

I authorize that email messages regarding my appointment time may be sent to the email I have listed. ___Yes ___No
I authorize that voicemail messages may be left at the phone number I have listed. ___Yes ___No
I authorize that I can receive text messages at the phone number I have listed. ___Yes ___No
I authorize that my email can be added to the 3RiversWell.com distribution list. ___Yes ___No

I hereby by consent and agree to receiving emails from Erin Bowman, PHD, LLC for appointment reminders. I understand that the risk of Protected Health Information (PHI) through email, and with this agreement I am accepting these risks to my PHI. I accept Dr. Bowman will not be responsible for any exposure of email communications at my home or place of employment, depending on the location of my email address. I also agree never to use email communications for emergency situations, and to call the office directly with any emergencies. I understand that I can terminate this agreement at any time by informing Erin Bowman, PHD, LLC in writing with my signature.

Signature Authorizing Communications: _____ Date: _____

Insurance and Medical Information Release Authorization

I authorize the release of any and all information required for insurance and payment purposes. I authorize Dr. Bowman to release necessary medical information to appropriate third parties for reimbursement purposes and/or to person authorized to conduct service utilization reviews. I understand that a photocopy of this authorization is as authentic as the original signed authorization.

Signature Authorizing Release of Medical Info: _____ Date: _____

Please consider following the 3Rivers Wellness Facebook page @3RiversWell.

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