



# Cranberry Psychological Center

100 Northpointe Circle, Suite 306  
Seven Fields, PA 16046  
Phone: (724) 772-4848  
Fax: (724) 772-4888

3402 Washington Road, Suite 304  
McMurray, PA 15317  
Phone: (724) 941-5363  
Fax: (724) 941-5464

1340 Old Freeport Road, 3<sup>rd</sup> Floor  
Pittsburgh, PA 15238  
Phone: (412) 406-8080  
Fax: (412) 406-8081

[www.cranberrypsychcenter.com](http://www.cranberrypsychcenter.com)

## **HOURS OF OPERATION:**

Weekdays: Appointments are offered 7:00am to 9:00pm (Clerical staff available M-F 9am to 5pm only)

Weekends: Appointments are offered 9:00am to 5:00pm (by clinician)

Our phone lines are answered and clerical staff is available Monday-Friday from 9:00am to 5:00pm only. You will be greeted and checked in by our front desk receptionist during that time frame, as well. Your therapist may schedule early morning, evening or weekend appointments when there may not be clerical staff at the front desk. When you arrive for these appointments, kindly take a seat in the waiting room, and your therapist will greet you.

**COPAYMENTS ARE TO BE PAID AT THE TIME OF APPOINTMENT.** During business hours, the clerical staff will collect your copay. After 5:00pm and on Saturdays, please remember to give your copay to your therapist.

## **EMERGENCY CONTACT INFORMATION:**

Phone: 724-772-4848 if you are seen at our Seven Fields office

Phone: 724-941-5363 if you are seen at our McMurray office

Phone: 412-406-8080 if you are seen at our Fox Chapel Office

During regular business hours, you will speak directly with our clerical staff. On rare occurrences, all lines may be in use at the time of your call and you may hear a recorded message. Please leave a message and we will return your call as soon as possible.

After regular business hours, our voice mail message system will prompt you to connect with our 24-hour answering service. They will locate your therapist in the event of an emergency and the therapist will call you directly. You may also elect to leave a routine message such as cancelling an appointment for the clerical staff, which will be retrieved the next business morning.

## **PRESCRIPTION REFILLS:**

You will be given enough medication to take you to your next scheduled appointment. If your scheduled appointment must be cancelled for any reason, reschedule it as soon as possible as appointments with our psychiatrists fill up quickly. Allow at least 1 week to obtain a prescription refill, and 2 weeks if you have a mail in prescription plan.

**IF YOU MUST CANCEL AN APPOINTMENT FOR ANY REASON, 24 HOURS ADVANCE NOTIFICATION IS REQUIRED OR A FEE WILL BE ASSESSED TO YOUR ACCOUNT. THERAPY SESSION - \$60.00, PSYCHIATRIST (MD) INITIAL EVALUATION - \$175.00, PSYCHIATRIST (MD) MEDICATION MONITOR SESSION - \$80.00.**

**Cranberry Psychological Center, Inc.**

**Data Intake Form**

**Patient Name:** \_\_\_\_\_ **Patient Sex:** M / F  
*If Child, Parents' Names* Mother: \_\_\_\_\_ Father \_\_\_\_\_

*If Child, Parents' Marital Status:* \_\_\_\_\_  
*If Child and parents are divorced/separated, which parent has custody?* \_\_\_\_\_

**Patient SS#** \_\_\_\_\_ **Patient Birth Date:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_

Phone: **(Pt.Home#)** \_\_\_\_\_ **(Pt.Work#)** \_\_\_\_\_ **(Pt.Cell#)** \_\_\_\_\_

**Would you like to receive appointment reminders by text? Y/N**

*If Child, Mother's Work#* \_\_\_\_\_ *Cell#* \_\_\_\_\_  
*Father's Work#* \_\_\_\_\_ *Cell#* \_\_\_\_\_

**Patient Marital Status:** single / married / divorced / separated / student  
*If Student, Name of School:* \_\_\_\_\_

**Is patient employed? Y / N** **Patient Employer:** \_\_\_\_\_  
 Full-Time  Part-Time

**Emergency Contact and Relationship:** \_\_\_\_\_

**Emergency Contact Phone Number:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **PCP Phone:** \_\_\_\_\_

**PCP Address:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Insurance Co. Phone:** \_\_\_\_\_

**Insurance Company Claims Address:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

**Insured Birth Date** \_\_\_\_\_ **Insured SS#** \_\_\_\_\_

**Patient's Identification#** \_\_\_\_\_ **Patient's Group #** \_\_\_\_\_

**Insured's Employer:** \_\_\_\_\_

How was the patient referred to our office? \_\_\_\_\_

Has the patient ever received psychological services in the past? \_\_\_ Yes \_\_\_ No

*If Yes, when and with whom?* \_\_\_\_\_

Is the patient taking any medications? \_\_\_ Yes \_\_\_ No

*If Yes, list?* \_\_\_\_\_

Is the patient allergic to any medications? \_\_\_ Yes \_\_\_ No

*If yes, specify?* \_\_\_\_\_

**Patient or Authorized Representative Signature:** I certify that all of the above information is correct. I voluntarily consent to receive treatment or have my minor child receive treatment at Cranberry Psychological Center, Inc. I authorize the release of any medical or other information necessary to process any insurance claims filed on behalf of myself or minor child. I also request that payment of benefits for services received be rendered directly to Cranberry Psychological Center, Inc. In the event that payment is made directly to the insured, I understand that I am personally responsible for payment of services rendered, unless the insurance check is presented to Cranberry Psychological Center, Inc. endorsed with the insured's signature and the words "payable to Cranberry Psychological Center, Inc." as soon as it is received.

\_\_\_\_\_  
Signature of Patient (or legal Guardian, if patient less than age 14)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Minor Child (age 14 to 18 only)

\_\_\_\_\_  
Date



# Cranberry Psychological Center

## *FINANCIAL AGREEMENT*

**PATIENT NAME:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

### **FORM OF PAYMENT FOR SERVICES RENDERED:**

- \_\_\_\_\_ I (We) will personally pay each charge in full.  
\_\_\_\_\_ I (We) choose to have charges submitted to insurance and pay amounts not paid by insurance.

It is the policy of CPC to collect payment in full for services rendered at the beginning of each appointment. Insurance co-payments are due at the time of service or a \$5.00 fee will be added to your account to cover billing costs.

### **UNDERSTANDING YOUR COSTS:**

While CPC strives to make sure all of your financial obligations for services are clearly explained to you, it is your responsibility as a patient to understand what your insurance covers and does not cover. CPC recommends you contact your insurance company by calling the number listed on the back of your insurance card and inquire about your mental health benefits allowing you to be aware of any costs that may become your responsibility as part of your treatment with us. By voluntarily consenting to receive our services, you acknowledge that you are personally responsible to pay CPC in full for services not covered by your health insurer.

### **OTHER SERVICES:**

Any additional services (other than office visits) such as letters, reports, phone contacts, depositions, court appearances, etc. are not covered by your insurance and will be billed if you request said services. For gastric bypass evaluations, forms submitted at the time of the session will be completed at no additional charge. For any other report or letter, a fee will be charged, and is not covered by insurance. A \$5.00 prescription fee will be assessed for prescriptions that must be called in to your pharmacy due to a missed medication management appointment or for failure to schedule a follow up appointment per the instruction of your psychiatrist. In addition, there will be a \$5.00 fee to cover the cost of mailing of samples and/or savings cards.

### **SCHEDULING AGREEMENT/NO SHOWS AND LATE CANCELLATIONS:**

In order for CPC to schedule you in a timely manner and allow for timely follow-up appointments, it is your responsibility to communicate when you are unable to keep your appointment not only as a courtesy to your provider and other patients, but also for administrative purposes as our staff prepares for each and every patient visit. A 24-hour advance notice is required to cancel a scheduled appointment. **Failure to comply with this policy and for non-attendance of a scheduled session will result in the following fees: Therapy Session - \$60.00, Psychiatrist (MD) Initial Evaluation - \$175.00, Psychiatrist (MD) Medication Monitor Session - \$80.00.**

### **OUTSTANDING BALANCES:**

It is the policy of CPC that patient balances should not exceed \$250 for sessions with a Therapist and \$200 with a Psychiatrist. If your patient responsibility balance becomes greater than this threshold, you will receive a courtesy call from our billing department. At this time, a payment agreement will be made and must be followed to continue your treatment with us. We will work with you to develop an affordable payment plan that both reduces your balance and meets any budget limitations you may have. However, if at any time it is determined that good faith payments are not being made on your account as agreed, CPC reserves the right to discontinue services until your account is current.

### **RETURNED CHECKS:**

A fee of \$30.00 will be charged to your account for a check returned to us for any reason.

**ALL FEES ARE SUBJECT TO CHANGE.**

**STATEMENTS:**

You will receive a monthly billing statement if a balance exists for which you are responsible as determined by your health insurer. The balance due may include deductibles, missed co-payments, coinsurance, denied claims, and any other services requested that are not covered by your health insurer. Payment is due within 30 days of receipt. You will be asked at your next appointment to pay any outstanding balance in full unless prior arrangements for payments have been made.

**DELINQUENCY:**

If your account should become delinquent, you will be responsible for finance charges of 1.5% for each month we do not receive payment. Minimum finance charge is \$5.00. Should the amount remain unpaid, the balance plus 35% for collection fees will be transferred to a collection agency.

**COMMUNICATION:**

CPC strongly believes that a good therapist/patient relationship is based upon understanding and open communication. If you have questions about bills that you receive or you have the need to make payment arrangements due to hardship, loss of insurance, job, or other, please contact our billing department and we will be happy to assist you in your options for continuing your care.

**MINOR CHILDREN:**

The parent(s) or legal guardian who brings a child to therapy or psychiatrist appointment is responsible for payment on the account. It is our policy to consider an 18-year old who is still in high school a "minor" for billing purposes. Charges for minor children will be billed to the parent with whom the child resides. Responsibility for payment of treatment of minor children whose parents are divorced rests with both parents. Financial responsibility stipulated by court-order must be determined between the individuals involved and without the inclusion of CPC.

**PERSON(S) FINANCIALLY RESPONSIBLE FOR ACCOUNT:** I (We), the undersigned, hereby agree to be financially responsible for this account and agree to the above terms.

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## ***ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION***

**Patient Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

I have been informed of the Privacy Practices for Cranberry Psychological Center, Inc. and Cranberry Psychological Center, Inc. is authorized to use and disclose health information for treatment, payment and healthcare operations for purposes consistent with its Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Patient or Parent/Guardian if child is under 18)*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Minor child if patient is 14 years of age or older)*

Printed name of legal representative (if applicable): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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# Cranberry Psychological Center

## Authorization to Disclose Information to Primary Care Physician

**Patient Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

Insurance companies require us to ask you whether we can notify your primary care physician regarding your treatment at Cranberry Psychological Center, Inc. Some facets of treatment, especially the prescription of medication, require coordination of care between healthcare providers. Although the decision is entirely up to you, it is highly recommended to maintain your overall good health. Please complete the bottom portion of this page. Check the appropriate line regarding coordination of care by checking the appropriate response. This authorization will remain in effect unless otherwise revoked by you. To revoke authorization, please submit your request in writing, ATTN: Compliance Officer.

I, \_\_\_\_\_, hereby  
*Printed patient name*

- Authorize** Cranberry Psychological Center, Inc. to release to my primary care physician any information deemed necessary by my therapist

Physician Name: \_\_\_\_\_  
Physician Address: \_\_\_\_\_

- Refuse to Authorize** Cranberry Psychological Center, Inc. to release information to my primary care physician

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Patient or Parent/Guardian if child is under 18)*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Minor child if patient is 14 years of age or older)*

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**Credit Card Authorization**

I authorize Cranberry Psychological Center to charge my credit card for any patient responsibility amount after claims are submitted and processed by my insurance company. These balances may include co-payments, coinsurance, deductibles, and other services. By signing below you acknowledge that you have read CPC's financial agreement policy.

Upon the termination of services, I understand that my credit card will be charged any remaining balance owed unless special payment arrangements have been agreed upon. I also understand if my card is declined and I have not made any payments towards my balance in 120 days, my account is considered inactive and may be sent to a credit collections agency.

Patient Name (Print): \_\_\_\_\_ Account#: \_\_\_\_\_

**I (print cardholder name), \_\_\_\_\_ authorize credit card payments for services rendered by Cranberry Psychological Center.**

Credit Card Type:

- MasterCard  
 Visa

- Discover  
 American Express

Name on Credit Card: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration date: \_\_\_\_\_ CVV: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_ Zip code: \_\_\_\_\_

***Please initial:***

\_\_\_\_\_ Missed appointments and late cancellations will be charged on your credit card according to the policies and fees specified on CPC's financial agreement.

**If you dispute your bill, we will always work with you to understand if there is a mistake. We will refund your credit card if your insurance company has made a billing error. We will only charge your credit card the amount we are instructed to by your insurance company in the EOB they send to us.**

**Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_