Anne Westcott, LICSW

Building Balance, 30 Domino Drive, Suite 2 Concord, MA 01742
o 978-226-8446 | f 978-405-5056
www.annewestcott.com | anne@annewestcott.com

REGISTRATION FORM

Name: _____ **Date of Birth**: _____ **Sex**: __M __ F
Marital:__S__M__D__W

Address: _____ **City**_____ **State** ___ **Zip** _____
Patient Bills to: _____

Address (If different)_____

Client Soc. Sec # _____ ___ _____

Employer: _____

Home Phone: _____
Number that messages may be left at : _____

Emergency Contact Name: _____
Contact Phone:_____
Referred By: _____
Primary Care Physician _____

Family Members/Others Living in Home

Name: _____
Occupation: _____
Relationship to Client: _____
Date of birth: _____

Name: _____
Occupation: _____
Relationship to Client: _____
Date of birth: _____

Name: _____
Occupation: _____
Relationship to Client: _____
Date of birth: _____

INSURANCE INFORMATION

**Attach Copy of Insurance Card (front and back)

Primary:
Name/Type: _____ Client ID # _____
Subscriber Name _____ Group/Plan # _____
Subscriber's Employer: _____ Authorization # _____

Secondary:
Name/Type: _____ Client ID # _____
Subscriber Name _____ Group/Plan # _____
Subscriber's Employer: _____ Authorization # _____

I authorize the release of information that may be required by my health insurance company and is necessary for treatment plan updates and to submit claims and pursue claim payments. I understand that Anne Westcott, LICSW, utilizes a billing person who may interact on her behalf with my insurance company. This billing person is also bound by state and federal rules of confidentiality. **I understand that I am financially responsible for all charges regardless of my insurance coverage.**

_____ _____
Signature of Patient or Adult Guardian (if minor) Date

- - - - - - - - - - - -- - - - - - FOR OFFICE USE ONLY - - - - - - - - - - - - - - - - - - -

Date of First Appointment: _____ DX: _____

Building Balance, 30 Domino Drive, Suite 8 Concord, MA 01742
Office 978-254-7875 Billing 978-264-4851

FEE SCHEDULE AND FINANCIAL POLICY

Clinical Services (May be Covered by Insurance):

Psychiatric Diagnostic Interview (45 min) CPT 90791:	$165
Individual Psychotherapy (45 min) CPT 90834:	$145
Individual Psychotherapy (60 min) CPT 90837:	$165
Family Therapy (45 minutes) CPT 90847:	$155
Interactive Therapy 90832+90875 (add-on):	$145
Parent Guidance (45 minutes) CPT 90846:	$145
Urgent extended Care (60 min.) CPT 90839	$165

Consultative Services (Not Covered by Insurance)

Written Reports by request	*$ 155 Per hourly rate*
Consultation (school, agency, another therapist)	*$150- $300*

Phone Consult over 15 minutes $45/30-45 minutes $100,/45-60 min $155
Travel time: First fifteen minutes or 30 minutes round trip travel (no charge) but thereafter, $155 per hour.

No Show/Late Cancels (Not Covered by Insurance)

Failure to keep a scheduled appointment without 24 hours advance notice will result in a full fee charge due from you at your next appointment. These may not be billed to your insurance company but are your responsibility.

Payment Policy:

- Payment is expected prior to or at the time of service for all self-pay clients.
- Insurance deductibles, and copays are due at the time of service. Payments can be made by **cash** in the exact amount or **check** made payable to: **Anne Westcott, LICSW**
- **Appointments cancelled without 24 hours notice are the responsibility of the patient**. This does not include weekends. To give adequate notice for a Monday apt you must cancel the preceding Friday. Charges for missed appointments or late cancellations must be paid in full at the next appointment.

Health Insurance:

- Please check with your insurer to determine policy limits, copayments, deductibles and whether your insurance for mental health is a "preferred provider panel" in which I participate. Your insurance benefit relationship is a "direct contract" between you and your insurer. Therefore you are responsible for knowing the number of sessions (or dollar amount) your policy covers, if pre-authorization is required, and at what level I am covered under your insurance.

I have read and agree to Anne Westcott, LICSW's Financial Policies. Please note that Fee Schedule Increases may occur based on increased costs but you would be notified in advance of any change.

_____ _____

Patient or responsible party Date