Pike Creek
PSYCHOLOGICAL CENTER

Acknowledgement of Receipt of New Patient Paperwork

I have read and agreed to the terms specified in the:

- Office Policies
- Privacy Practices
- Consent for Treatment
- Reminders and Patient Portal

By signing below, I am giving my informed consent for treatment for myself or my dependent. I also agree to abide by the terms of the various documents and understand that Pike Creek Psychological Center may change these documents periodically, and that I may receive a current copy of the documents by contacting the Newark branch listed below.

Client's Name (print): _____ DOB: _____

Signature: _____ Date: _____

****Both parents must consent in joint custody cases.****

This release expires at end of treatment.

Please give us a phone number on which we are authorized to leave a message: _____

Please name a person whom we may contact in case of emergency:

Name: _____ Relationship: _____

Phone: _____

Newark Branch
8 Polly Drummond Hill Rd
Newark, DE 19711

Middletown Branch
252 Carter Drive, Suite 100
Middletown, DE 19709

Phone (302) 738-6859
Fax (302) 368-5309
www.PikeCreekPsych.com

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INSURANCE AUTHORIZATION

If I am using insurance to pay for treatment, I hereby authorize Pike Creek Psychological Center to release the information necessary to my insurance company for treatment and payment. I assign all benefits for services to which I am entitled to Pike Creek Psychological Center. This assignment will remain in effect until revoked by me in writing. The information disclosed may be subject to re-disclosure by the recipient. A photocopy of this assignment is considered as valid as the original.

I understand that it is my responsibility to know what my outpatient mental health benefits are as defined by my insurance policy. Pike Creek Psychological Center will contact my insurance company to obtain these benefits as a courtesy only.

I am aware that my contract with my health insurance company requires that I provide my health insurance company with information relevant to the services provided by Pike Creek Psychological Center. Pike Creek Psychological Center is required to provide a clinical diagnosis. Sometimes Pike Creek Psychological Center will be required to provide additional clinical information such as treatment plans or summaries, or copies of my entire medical record. By signing this agreement, I agree that Pike Creek Psychological Center can provide the requested information to my health insurance company.

I understand that claim payment cannot be guaranteed at the time of service and that my insurance company will make final determination upon receipt of claims. I agree to pay any legally collectable balance on my account for fees incurred that are not covered by insurance and/or are left unpaid by my insurance company. These fees may include co-pays, co-insurance, deductibles, missed appointment fees and other service fees.

Name: _____ DOB: _____

Signature: _____ Date: _____

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