Jeffry Stine, Psy.D
Licensed Clinical Psychologist
4044 N. Lincoln Ave, Suite 461
Chicago, IL 60618
Phone (224) 388-3633
Fax: 847-929-4513

I, ____________________________give my consent to receive psychological services by Dr. Jeffry Stine. **I have read the Services Contract and HIPAA Notice** and discussed any questions I may have with my provider. By signing, I certify I fully understand and agree to abide by the terms of the service contract.

____ ___________
Client Signature (age 12 and older must sign) Date

____ ___________
Parent/Guardian Date

____ ___________
Jeffry Stine, Psy.D Date

FOR CHILDREN AND ADOLESCENTS:

I, ____________________________ am the parent/legal guardian of the child/adolescent seeking treatment and have read and understood the additional considerations pertaining to treating children and adolescents as outlined in the service contract.

____ ___________
Client Signature (age 12 and older must sign) Date

____ ___________
Parent/Guardian Date

____ ___________
Jeffry Stine, Psy.D Date

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FINANCIAL CONTRACT

My fee for psychotherapy is $170 per session. If you have health care insurance, my services are covered by Blue Cross Blue Shield PPO, United Health Care, Cigna, and Magellan. Payments for sessions, which may include co-pays, are expected at the beginning of each session in the form of cash, check, or credit card. After I have received your estimated cost and benefits summary, we will discuss co-pays, co-insurance, or deductibles for which you may have the responsibility to pay.

If your insurance carrier is not one I am a provider in, your care may be considered out-of-network. This does not mean services are not covered. It is your responsibility to contact your insurance carrier to confirm your mental health benefits. If needed, I can provide statements for you to submit to your health insurance company. You will be responsible for any additional fees for service.

If paying your bill becomes a challenge, please discuss this with me so we can come to a solution. If no solution has been discussed and your account has not been paid for more than 60 days, I may use a collection agency to secure payment for services provided.

Method of Payment:

- ☐ Insurance
- ☐ Check
- ☐ Debit/Credit Card
- ☐ Cash

Insurance Company Information

Insurance Company:____

Subscriber Name:________________________________Subscriber DOB:______________

Identification or Policy #:____

Group #_______________________Insurance Company Phone #:____________________

Client’s relationship to Subscriber (e.g. self, spouse, child):______________________

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Please initial to indicate you understand and agree to the following:

_________I agree that a financial relationship with Jeffry Stine, Psy.D will continue as he provides services to me. I agree to pay for services provided through the termination of services.

_________I certify that I or my dependent has insurance coverage with the health insurance provider stated above. I acknowledge and authorize Jeffry Stine, Psy.D to bill and/or release all appropriate information as may be necessary to process claims and to secure the payment of benefits. I authorize the use of this signature below on all insurance submissions.

_________I understand that I am responsible for payment for the services rendered by Jeffry Stine, Psy.D even though insurance companies and other individuals may make payments to my account.

_________I give permission to release any information needed for third-party submission or payments for services. I authorize these payments to be made to Jeffry Stine, Psy.D for the services outlined in the Services Contract.

____ _______________
Client Signature (Or party assuming financial responsibility) Date

____ _______________
Jeffry Stine, Psy.D. Date

Self-Pay (if applicable)

I am aware of the cost of psychotherapy and/or services offered and aware that I am responsible for charges agreed upon. The cost for initial evaluation is $______. The cost for an individual therapy session is $_______. The cost for a family therapy session is $_______.

____ _______________
Client Signature (Or party assuming financial responsibility) Date

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RECURRING CREDIT CARD PAYMENT AUTHORIZATION

I authorize payments for sessions or late cancellations from Jeffry Stine, Psy.D, using this credit card authorization form. Credit card transactions will be done through Ivy Pay, which is a HIPAA compliant credit card processing company. I further authorize Jeffry Stine, Psy.D to maintain my card information on file. I agree that I will pay for these sessions or late cancellations and indemnify and hold Jeffry Stine, Psy.D harmless against any liability pursuant to this authorization. I understand that my signature on this form will serve as the authorized signature on the credit card charge slip. This authorization will remain in effect until such time when a written request to cease charges is received. Jeffry Stine, Psy.D will process all charges using a secure credit card service. Charges will be processed to the above stated account 1 to 5 business days after the session date or late cancellation.

Last 4 digits of credit card number to be stored by Ivy Pay:___________________.

CVC Code:______________.

Credit card expiration date:________/_________

Address associated with debit/credit card:

Name:_____________________________

Address:_______________________________________City:__________________

State:______________Zip:_____________________

_______________________________________ _____________________

Signature of Authorized Card Holder Date

____

Printed Name