SHARON CHIRBAN PHD
CLINICAL SPORT PSYCHOLOGIST
Eating Disorder and Performance Enhancement Specialist

AMPLIFYING PERFORMANCE CONSULTING, LLC

I. BASIC INFORMATION:

Client's Name:_____ Age: _____

Date of Birth: _____ Sex: Male _____ Female _____

Phone Numbers:

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Email Address: _____

AMPLIFYING PERFORMANCE CONSULTING, LLC

Client Information Form

Present Address:

_____
_____
_____

Permanent Home Address: (if different from above)
_____
_____
_____

Place of Employment: _____

II. ARE YOU SEEKING SERVICES FOR:

____ Yourself

____ Your Child give age _____

____ You and your spouse/partner/family; also complete V below)

____ Other: _____

Reason for Requesting Services:
_____

_____

Referred by: _____

Previous Mental Health Care: Yes _____ No _____

(If yes) Provider(s): _____ **Date:** _____

Provider(s): _____ **Date:** _____

Name of your Physician: _____

Phone: _____

III. PERSONS TO CONTACT IN AN EMERGENCY:

Name: _____

Relation to Patient: _____

Phone: _____

Name: _____

Relation to Patient: _____

Phone: _____

Yes _____ Yes _____ Yes _____ Yes _____

No _____ No _____ No _____ No _____

IV. INFORMATION NEEDED IF YOU ARE SEEKING COUPLES THERAPY

Additional Client Name: _____

Age: _____ **Birth date:** _____

Sex: Male _____ Female _____

Present Address (only if different from above): _____
_____ _____

Ok to leave message?

Phone: _____**(cell) Phone:** _____**(home) Phone:** _____**(work)**

Yes _____ Yes _____ Yes _____

No _____ No _____ No _____

Place of Employment: _____

Occupation: _____

Previous Mental Health Treatment: Yes ____ No _____

Date(s): _____

Treatment Provider:
_____

Emergency Contact: _____

Phone #: _____

Client Name: _____

VII. FEE AGREEMENT

Billing will occur at the end of each month for psychological services at the rate of $150-300 per 45 to 50 minute session depending on the staff member. Charges for legal consultation, testimony, and telephone consultation should be discussed with your clinician.]

I UNDERSTAND THAT MISSED APPOINTMENTS THAT ARE NOT CANCELLED 48 HOURS IN ADVANCE WILL BE CHARGED. THESE MISSED APPOINTMENTS CANNOT BE FILED WITH MY INSURANCE CARRIER AND I WILL BE HELD FINANCIALLY RESPONSIBLE.

_____ (Initials)

At your request, we will bill your insurance carrier directly. We cannot guarantee if or what your insurance will pay. It is the patient's responsibility to know what their outpatient mental health benefits are. The patient's share of the fee, including deductible, is due at the time of service. Payment in full, for the initial session is due at that time. Whoever is specified as responsible for the bill must pay for all fees in the event of nonpayment or reduced payment by your insurance company. Parents of college students will be billed only after they have signed a fee agreement. Should your account become delinquent, your name and other information relevant to collections may be turned over to a collection agency. You will be responsible for all collection expenses, attorney fees, and court costs expanded in the resolution of the account.

LEGAL / FORENSIC CHARGES

Depending on the forensic issue, your psychologist may not be willing to become involved in legal proceeding and may decline to do so. In the even that legal involvement concerning you does occur, charges for legal consultation and/or testimony will be billed

at $300 to $500 per hour, to be agreed in advance in consultation with your psychologist. Insurance will not pay for these expenses and will not be filed under these circumstances. In the event that you become involved in litigation, you agree to pay at the forensic rate for all time spent by your psychologist on court related matters, including but not limited to:

1. Responding to subpoenas by attorneys for either party

2. Preparation for the case
3. Phone calls
4. Record copying and mailing

5. Time traveling to and from court
6. Time testifying in court
7. Time spent in a courthouse waiting to be called for testimony
8. Any other legal expenses incurred by the psychologist to respond to your legal case

I HAVE BEEN ORIENTED AS TO MY RESPONSIBILITES REGARDING MY FEE AND UNDERSTAND AND AGREE THAT I WILL BE RESPONSIBLE FOR PAYMENT OF THE BILL IN FULL.

Patient Signature: _____

Date: _____

Person Responsible for Payment Signature: _____

Date: _____