Creative Behavior Consulting

Lisa S. Kovitch, MA, BCBA, LPC

Evidence-Based Applied Behavior Analysis with a creative, natural, and dynamic approach

Patient Financial Registration Form

Today's Date_____

_____ _____ _____ M___F _____
Patient Last Name First Name Date of Birth Group # Sex ID number:

_____ _____ ____ _____ _____
Street Address City ST Zip Home Telephone

_____ _____
Mailing Address (if different from street address) Alternate Telephone

Subscriber Information:

_____ _____ _____ M___F _____
Last Name MI First Name GROUP # Sex SS#

_____ _____ ____ _____ _____
Street Address City ST Zip Home Telephone

_____ _____ _____
Employer Name Address Work Telephone

_____ _____
Email Date of Birth

Emergency Contact

Name: _____ Telephone: _____ Relationship: _____

Address: _____

Hours of Therapy Requested:

Monday_____ **Tuesday**_____**Wendsday**_____**Thursday**_____**Friday**_____
Additional Therapy Requested on weekends;_____

Medical History:

Diagnoses:_____
Behavioral Concerns:_____
Other Concerns:_____

List of Medications+dosages:_____

Phone: 570.982.9486
Fax: 678.669.2632
lgrankovitch@yahoo.com

Lisa S. Kovitch, MA, BCBA, LPC

Evidence-Based Applied Behavior Analysis with a creative, natural, and dynamic approach

Insurance and Financial Responsibility:

Consent and Release

I hereby consent to treatment by, and authorize insurance benefits to be paid directly to Lisa S. Kovitch, MA, BCBA, LPC. I agree that I am responsible to pay 1) for services not covered by my insurance company, 2) co-payments and deductibles, and 3) any expense associated with the collection of a debt owed to them by me (i.e. Attorney fee, court cost or collection agency fee). I also consent to the release of pertinent medical information to my insurance carrier(s) for the purpose of processing health care claims.

X_____ _____ _____

(Signature of Responsible Party) **(Date)** **(Witness)**

Insurance Recipients

Lisa S. Kovitch, MA, BCBA, LPC provides Behavioral Therapy and will submit all claims in your behalf but all eligibility verifications and/or authorizations are estimate of payment and are not a guarantee of payment. Patient is responsible for all unpaid claims by their insurance carrier, copays and applicable deductibles. By signing below I except financial responsibility.

X_____ _____ _____

(Signature of Responsible Party) **(Date)** **(Witness)**

Phone: 570.982.9436

Fax: 678.669.2632

lgrankovitch@yahoo.com

Lisa S. Kovitch, MA, BCBA, LPC

Evidence-Based Applied Behavior Analysis with a creative, natural, and dynamic approach

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I,_____, do hereby authorize: Lisa S. Kovitch, MA, BCBA, LPC. Including all employees/contractors, to exchange information from the record of (Print Client Name)_____
DOB: _____

- Physical Examination _____
- Birth Record _____
- Medical Examination _____
- Psychological Examination _____
- Psychosocial History _____
- IEP/IFSP _____
- Progress Reports _____
- Education Records _____

I understand that Lisa Kovitch, MA, BCBA, LPC will keep information and documentation confidential. I understand that this consent to release information is valid for the period of time in which the above named person is an active client.

I understand that I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose(s) specified above.

I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon), by written, dated, communication to with Lisa Kovitch, MA, BCBA, LPC

_____

Signature of Parent/Guardian Date

Phone: 570.982.9436
Fax: 678.669.2632
lgrankovitch@yahoo.com

Lisa S. Kovitch, MA, BCBA, LPC

Evidence-Based Applied Behavior Analysis with a creative, natural, and dynamic approach

Information Related to Scheduling and Sessions

Sessions for Assessment and Behavioral Therapy are usually scheduled in several hour blocks, however in some cases it may be less or more time per session as it is tailored to the individual child. The research is clear that longer sessions result in greater retention and this makes scheduling more convenient for all parties. If this is not convenient for your family, please bring this up during at the intake meeting.

Except in cases of emergency, 12 hours' notice is required for all cancelled appointments. Payment for the appointment is required for all missed appointments not cancelled according to this policy.

Insurance carriers are not responsible for miss appointment fees.

We request that families give us at least two weeks' notice on significant changes in their plans for scheduling in order to facilitate consistency in service delivery.

The universal standard for therapy, be it the insurance standards or the professional standards of various organizations like the APA, ASHA, etc., is that a therapy: "hour" is 45-50 minutes of direct contact with the patient with the remaining 10-15 minutes devoted to required record keeping and other administrative requirements. Typically, for a 3-hour in home therapy session, our staff take 10 minutes to arrange the materials prior to commencing direct therapy with the child and ~ 15 minutes at the end to record data, tidy the setting, and discuss the session with the parent.

Phone: 570.982.9436
Fax: 678.669.2632
lgrankovitch@yahoo.com

Lisa S. Kovitch, MA, BCBA, LPC

Evidence-Based Applied Behavior Analysis with a creative, natural, and dynamic approach

INFORMED CONSENT FOR BEHAVIORAL SERVICES:

I hereby voluntarily apply for and consent to services by Lisa S. Kovitch MA, BCBA, LPC. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information.

_____ _____

Signature Date

_____ _____

Printed Name Name of Client

Phone: 570.982.9436
Fax: 678.669.2632
lgrankovitch@yahoo.com