PLEASE COMPLETE BOTH SIDES

Theodore Henderson, M.D., Ph.D.
Dr. Theodore Henderson, Inc.
3979 E. Arapahoe Road
Suite 200
Centennial, Colorado 80122

PATIENT INFORMATION

Patient Name _____ **M** **F** Gender

Date of Birth _____ Age _____ Home Phone Number _____

Street Address _____ Cell Phone Number _____

City _____ State _____ Zip Code _____ Work Phone Number _____

Mother's Name _____ Father's Name _____

Mother's Address (if different) _____ Father's Address (if different) _____

Work Phone # _____ Cell/Pager # _____ Work Phone # _____ Cell/Pager # _____

Employer _____ Employer _____

Employer's Address _____ Employer's Address _____

Who Referred You to Our Office _____ **Pediatrician's Name and Telephone Number** _____

INSURANCE INFORMATION (Please provide complete information)

Name of Party Responsible for Payment of Services _____ Phone Number of Responsible Party _____

Address of Responsible Party _____

Insurance Company and Address _____

Insurance Company Phone # _____ Policy # _____ Policy Holder's Name _____ Policy Holder's SSN _____

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing the best possible care. Our goal is that your or your child's treatment will be successful. Please understand that payment is considered a part of your or your child's treatment. Please read the following Financial Policy Statements and sign the statement below.

1) **Full payment is required at the time of service**.
2) We accept cash or checks. A $40.00 charge will be added for any check returned for insufficient funds.
3) Unless cancelled at least 24 hours in advance (the prior Friday for Monday appointments), our policy is to charge for missed appointments. You will be responsible for settling that charge at the next appointment.
4) The standard of this practice is for appointments a minimum of once every three (3) months. Prescriptions will not be refilled if this minimum standard is not met.
5) We are not participating providers for any insurance plans. However, we will provide a receipt and additional documentation, if requested, to facilitate submitting claims. Please be aware that you are responsible for all charges for professional services rendered on behalf of the identified patient, including any charges not reimbursed by your insurance carrier. Note that some services may not be covered by your insurance, such as services provided outside of scheduled appointment times, including phone calls, letters, reports, faxes, copying of records, or consultations with other providers, schools, or insurance companies.
6) Dr. Henderson is an independent practitioner and any other professionals sharing office space also are independent practitioners. Office space is shared for convenience only. There is no partnership between these independent practitioners.
7) Charges are assessed based on a standard fee of $330/hour.
   Appointments of 20 minutes are billed at $110; appointments lasting 30 minutes are billed at $165.
   Other appointments will be billed based on the applicable portion of the base fee.

I have read the Financial Policy. I understand and agree to the terms of the Financial Policy. I understand that I am responsible for services provided and for any collection or attorney fees, or court costs associated with use of outside agencies required for collection of fees.

Patient Signature (if over 15) _____ Date _____

_____ Date _____
Signature of Responsible Party

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of the information provided herein and any medical information necessary to:
1) provide adequate coverage in the absence of the primary psychiatrist
2) communicate with and/or write a report to my referring physician or therapist
3) provide additional limited documentation to insurance company, as requested and discussed with the responsible party, prior to any distribution of information.

Patient Signature _____ Date _____

Responsible Party _____ Date _____