Nicole Ranttila, Psy.D.
Licensed Clinical Psychologist

725 Boardman-Canfield Rd., Suite K5
Boardman, Ohio 44512
Phone: 330.550.8274

Patient Information

Full Name _____ DOB _____ Circle: M F

Address _____City/State/Zip_____

Primary Phone _____ Alt Phone _____

Responsible Party Information

Name _____ Relationship to Patient _____

Address (if different) _____

Phone _____ DOB _____ Marital Status _____

Employer _____

Primary Insurance Information

Insurance Company _____ Name on Policy _____

Relationship to Patient _____ Date of Birth _____

Policy ID Number _____ Group Number _____

Insurance Billing Address: _____

Secondary Insurance Information

Insurance Company _____ Name on Policy _____

Relationship to Patient _____ Date of Birth _____

Policy ID Number _____ Group Number _____

Insurance Billing Address: _____

Patient Agreement and Assignment of Benefits: I hereby assign Nicole Ranttila, Inc. all benefits to which I am entitled from all private and public medical insurance plans including Medicare and Medicaid. I understand I am financially responsible for all treatment charges for services rendered by Nicole Ranttila, Inc. regardless of any limitations of insurance coverage, divorce agreements, or victim's assistance. I understand I must pay all copayments and deductibles in full. I understand I will be charged for appointments missed unless 24 hours' notice is given to Dr. Ranttila. I understand all deductibles and copayments must be paid in full at each visit/service. I understand that my coverage is part of a contractual agreement between Nicole Ranttila, Inc. and a specific third party payer. Nicole Ranttila, Inc. agrees to abide by the regulations and reduced rates outlined in those contracts. I hereby agree to the above and thus authorize Nicole Ranttila, Inc. to release information about my condition and treatment to those who are part of the process of securing insurance payment for same. I acknowledge that a photo copy of this assignment and authorization is as valid as the original. If I do not sign this agreement, I will pay for each service in full at each visit.

Signature of Insured/Responsible Party: _____ Date: _____
AND
Signature of Patient/Parent/Guardian if under 18: _____ Date: _____

Nicole Ranttila, Psy.D.
Licensed Clinical Psychologist

725 Boardman-Canfield Rd., Suite K5
Boardman, Ohio 44512
Phone: 330.550.8274

Contractual Fee Agreement and Consent for Treatment

1. ***Fees:*** My standard fee is $200 for an initial evaluation and $50 for each 15 minutes of service (e.g., $200 for a one hour session, $150 for a 45 minute session). Psychological assessment, consultation, workshops, or groups may involve additional or separate charges. Payment is due at the time of the session. Any other arrangements are made on a case by case basis. Phone sessions are billed on a per-minute basis starting for phone calls over 10 minutes in length. A sliding scale is available for services based on personal circumstances. In cases of shared custody or any situation in which billing is shared between more than one party, the individual who presents the patient for treatment is responsible for payment of copayments/deductibles. I cannot bill multiple households for services. The credit card company charges me a 3.5% surcharge for any manually entered charges. This surcharge will be added to any manually entered payments.

1. ***Appointment Cancellations:*** Fees are based on the time I commit to work with you in sessions. Please understand that in the case of late/last minute cancellations or no shows, someone who needed an appointment was unable to be served. Therefore, to keep fees low and service all clients, a fee of $60 will be charged for any sessions not cancelled 24 hours in advance.

2. ***Fee Agreement:*** By signing this contract, I affirm that I have fully read and understand the terms of this contract**. <u>I acknowledge I am responsible for all copayments and fees not covered by my insurance</u>**. My insurance is billed $200 for each initial evaluation, $200 for each 53-60 minute follow up appointment or testing session, $150 for each 45-52 minute follow up therapy testing or therapy session.

3. ***OPTIONAL Sliding Scale (if applicable):*** I am responsible for a fee of $_____ for each session Sliding scale sessions are not billable to insurance.

Fees are due at the time of the scheduled session unless other arrangements are made in advance. If there is a balance is on the account, it must be paid at the appointment. My signature indicates I understand this policy. This fee may be renegotiated in a new Fee Agreement Form as financial situations with this corporation change. In the unlikely event that check funds are not honored, I give authorization for the funds to be collected electronically for the face value of the check plus a $25 processing fee. I understand that Nicole Ranttila, Inc. keeps a credit card on file for me in the event have an outstanding balance over 120 days and have not made arrangements for payment. If my account becomes delinquent due to nonpayment, I agree that I am responsible for the cost of services performed, any missed visits, interest of 1.25% per month, collection agency fees, court costs, and any other costs associated with the collection of my debt. I understand my insurance company may pay all, some or none of the amount due to Nicole Ranttila, Inc. and I assume responsibility for any and all unpaid balances.

By signing this contract, I give permission for the psychological evaluation, treatment, testing, or consultation regarding the named patient. I give consent for my insurance to be charged for services. I have read and understand the HIPAA Compliance Policy. I understand I can request a copy of the HIPAA Compliance Policy at any time.

Patient Name: _____

Signature of Patient or Responsible Party: _____ Date: _____

Nicole Ranttila, Psy.D.
Licensed Clinical Psychologist

725 Boardman-Canfield Rd., Suite K5
Boardman, Ohio 44512
Phone: 330.550.8274

Credit/Debit/HSA Card Preauthorization Form
For Psychological Treatment, Missed Appointments, Past Due Balances

I require your credit card information for the following events:

- If you miss an appointment without providing 24 hours' advance notice, you will be charged $60 for the missed appointment fee. This fee may not be submitted to insurance.
- If you have an outstanding balance past 120 days, I will notify you in writing that your card will be charged for the outstanding balance within 15 days if you do not call this office to make full or partial payment or set up an agreed upon payment plan.
- For copayments, deductibles, or if you are paying out of pocket for services, I can charge for sessions for each visit. You may also pay via cash or check at each appointment.
- The credit card company charges me a 3.5% surcharge for any manually entered charges. This surcharge will be added to any manually entered payments.

I hereby authorize Nicole Ranttila, Inc. to keep my credit or debit card and signature on file and charge my listed credit card for recurring charges of $60 for missed appointments in which I have not provided 24 hours' notice and for any balances 120 days past due (unless I have made alternative, agreed upon arrangements with Dr. Ranttila).

I authorize Nicole Ranttila, Inc. to keep my signature on file and charge my listed credit card for my $_____ per session copayment. I authorize Nicole Ranttila, Inc. to charge for additional associated fees as discussed at each session (i.e., payment of deductible, coinsurance as claims are remitted to Dr. Ranttila).

I understand this form is valid for one year unless I cancel the authorization in writing. I promise not to dispute charges ("charge back") for sessions I have received or that I have not cancelled with 24 hours' advance notice. I further authorize Nicole Ranttila, Inc. to disclose information about my attendance/cancelled session(s) to my credit card issuer if I dispute the charge(s).

Patient Name _____

Cardholder Name _____

Cardholder Billing Address
_____

Card Number _____ Expiration Date _____

CVV/Security Code _____

Cardholder Signature _____ Date _____