FINANCIAL AGREEMENT
WELL BEING SYSTEMS, PLLC

WELL BEING SYSTEMS, PLLC is a private practice psychiatrist group. Due to the administrative work of filing insurance and constraints of optimum care a limited number of insurance companies will be accepted. Please check our website www.draburstein.com for current insurance information or call our office.

Professional Fees:

- Co-payment or balances are due in full at time of service.
- Special financial arrangements must be discussed **prior** to your appointment.
- Parents/Guardians are financially responsible for payment for services provided to minors, or other legal dependents.
- $35 processing fee will apply for any returned check.
- Fees may include charges for other professional services such as
    1. Report writing
    2. Telephone conversations
    3. Consulting with other professionals
    4. Preparation of records or treatment summaries
    5. Psychological testing
    6. Legal proceedings, including preparation time and transportation

Insurance Benefits:

It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the section in my insurance coverage booklet that describes mental health services. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered by my insurance plan. Insurance information must be received in a timely manner. We will not retroactively bill claims that are older than 90 days. Any claims older than 90 days must be billed to the insurance by the patient.

I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self pay basis. I will present my insurance card at the time of my appointment. **I will provide updated insurance information prior to my appointment in case of any changes.**

I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party.

I understand that, if after 90 days, my insurance company has not responded, I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

Policy for Missed Appointments and Cancellations:

Appointment times are reserved exclusively for you; If you do not cancel your appointment, you will be charged the full amount of the scheduled time. To avoid any missed appointment or late cancel fees, please call 24 hours in advance to make any changes to your appointment.

I agree that I must give proper notification to cancel an appointment to avoid any late cancellation or missed appointment fees. I agree to call at least **24 hours** in advance to cancel or change my appointment. For Monday appointments, I will call the previous **Friday by noon.**

BY SIGNING THIS FINANCIAL AGREEMENT, I HAVE READ ALL ITEMS AND ACCEPT THE TERMS

____
Patient or (Authorized Parent/Guardian Name) **Printed**

____ _________________________

WELL BEING SYSTEMS, PLLC
PATIENT – CLIENT INFORMATION

LEGAL Name_______________________________ Date of Birth____________ Today's Date___________
(must match insurance card)

Address_____________________________________ City________ State____ Zip_____

Mailing Address______________________________ City________ State ____ Zip_____
(If different)

Phone: Cell ________________________ Home ______________________
Appt. reminders are text, voice and email

Email: ____

Person responsible for your account ____________________________ relationship______

Ethnicity (circle): Hispanic____ Non-Hispanic______ Race:__________ I choose not to answer____________

Preferred language:________________

Relationship status: Single Married Partnered

Name of Spouse/Partner (parents/guardian for minor)________________________________

Children & Ages (siblings for minor) ____

I GIVE PERMISSION FOR DR BURSTEIN TO RELEASE AND/OR RECEIVE MEDICAL OR FINANCIAL INFORMATION, WHICH MAY INCLUDE PROTECTED HEALTH INFORMATION, TO THE FOLLOWING PEOPLE, NOT INCLUDING HEALTH CARE PROVIDERS: (***OPTIONAL***)

NAME ______________________ RELATIONSHIP_________ Patient Initials ________

NAME ______________________ RELATIONSHIP_________ Patient Initials ________

Please note: Separate authorization form needed to release/receive information from health care providers. This form will be given upon request.

Name of referring physician ____________________________________

In case of emergency notify _______________ Relationship________Phone_____________

REFERRED BY - IF OTHER THAN YOUR DOCTOR______________________________

Please explain why you are seeking help at this time:

____

____

Please explain how your problems are affecting your work and relationships, plus your general functioning:

____

____

____

____

Patient name__________________________________ Date of Birth_______________

On a 1 to 10 scale, with 1 = no distress and 10 = extreme distress, please rate your distress level now: _________

Please check any health problems you have or have had:

_____lung
_____liver
_____kidney
_____stomach/intestinal
_____high blood pressure
_____diabetes
_____seizures
_____head injury
_____arthritis
_____other pain
_____cancer

Medicines you are allergic to:

____
____

Medicines you now take:

____
____
____
____

How much and what kind of exercise you get:

____
____

Height ________________ Weight ________________

SUBSTANCE USE	Average amount Past 2 months	Most ever used
Coffee	______________________	_________________
Cigarettes	______________________	_________________
Alcohol	______________________	_________________
Recreational Drugs	______________________	_________________

Please rate your level of difficulty with these problems: 0 = none 1 = mild 2 = moderate 3 = severe

___Physical health
___Chronic Pain
___ Low mood
___ Mood swings
___ Energy/motivation level
___ Memory
___ Concentration
___ Sleep
___ Sexual functioning
___Suicidal thoughts
___ Spirituality/religion
___ Marriage/relationship
___ Family conflicts
___ In-law problems
___ Job or school performance
___Friendships
___Financial problems
___ Obsessions (unwanted thoughts)
___ Nightmares
___ Thoughts of hurting someone
___ Compulsions (unwanted actions)
___ Flashbacks
___ Paranoid thoughts
___ Domestic violence (verbal)
___ Domestic violence (physical)
___ Drinking alcohol
___Using drugs
___Panic Attacks
___Phobias
___ Anxiety symptoms
- ___*sweating*
- ___ *short of breath*
- ___ *stomach upset*
- ___*dizziness*
- ___ *choking*
- ___ *racing heart*
- ___ *weakness*
- ___*dry mouth*
- ___*feeling trapped*
- ___ *panic*