SHARON CHADA, PH.D.
CLINICAL PSYCHOLOGIST
50 SUGAR CREEK CENTER BLVD.
SUITE 250
SUGAR LAND, TX 77478

Patient Information

Name: _____ Date of Birth: _____

Address:_____

City: _____ State: _____ Zip: _____

Email:_____ Gender: M F Age: _____

Home Phone:_____ Cell Phone: _____

Marital Status: _____ # of Marriages: _____ # of Divorces: _____

Social Security #: _____ TX Driver's License: _____

Employer: _____

Employer's Address: _____

Job Title: _____

Name of Spouse or Parent: _____Relationship: _____

Address:_____

City: _____ State: _____ Zip: _____

Marital Status: _____ # of Marriages: _____ # of Divorces: _____

Gender: _____ Age: _____ Date of Birth: _____

Social Security #: _____ TX Driver's License: _____

Employer: _____

Employer's Address: _____

Job Title: _____

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Others in Household:

Name: Relationship: D.O.B./Age: Gender:

_____

_____

_____

_____

Please list current medications and their purpose:

Name: Dosage/Frequency: Date Began: Side Effects: Condition:

_____

_____

_____

_____

I certify that this information is true and correct to the best of my knowledge. I will notify you of changes in my health status or the above information.

Reason for Seeking Psychotherapy or Evaluation:

_____

_____

_____ _____

Signature **Date**

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I give permission for myself (or minor child) to receive psychological assessment and/or therapy from Sharon Chada, Ph.D.

_____ _____

Signature of Patient (or guardian, if minor) **Name of patient if minor child**

_____

Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the HIPPA Privacy Practices to protect the privacy of personal health information.

Patient (or Guardian's) Signature: _____

Patient's Name: _____

Date: _____

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About Financial Arrangements and Insurance Benefits

I am committed to providing you with the best possible care. In order to achieve this goal, your assistance and understanding of my payment policy is important.

Payment for services is due and payable at the time services are rendered.
My rates are:

Initial Evaluation:	**$160**	**60 minutes**
Individual Therapy:	**$135**	**45 minutes**
Forensic Evaluation:	**$160**	**45 minutes**
Court Appearance:	**$250**	**per hour, 4 hour minimum**

Report writing, document review, other paperwork and telephone conversations over seven minutes will be billed in 15 minute pro-rated increments, depending on whether they are at the psychotherapy or forensic rate.

I accept cash, personal check, Visa, MasterCard and American Express. Returned checks are subject to a $25 returned check fee. Any balance older than 30 days will be subject to additional collection fees and interest charges of 18% on the unpaid balance.

If for any reason you cannot keep your appointment, please call and leave me a message at least 24 business hours before your scheduled appointment, or usual charges will be made to your credit card on file. Insurance companies will not pay for missed appointments.

Authorization of insurance benefits is not a guarantee of payment for services rendered. You are ultimately responsible for any unpaid balances.

It is your responsibility to notify me beforehand of any changes with your insurance. Please allow time for your insurance company to preauthorize benefits.

_____ _____
Signature **Date**

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Having this card on file is mandatory. It will not be used without prior notice, except in the case of "no-shows", and only for the purpose listed below.

I have provided Sharon Chada, Ph.D. with my credit card number and authorize her to keep my signature on file, and to charge my credit card account for:

- **insurance payments paid directly to me that were due to her office**
- **missed appointments or those cancelled with less than 24 business hours notice (unless an emergency)**
- **overdue unpaid balances**

I understand that this form is valid for one year unless I cancel the authorization through written notice to her.

Patient's name: _____

Please circle: VISA MASTERCARD AMERICAN EXPRESS

Charge Card Number: _____

Expiration Date: _____ V Code: _____

Cardholder's Signature: _____

Date: _____

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I give permission for Sharon Chada, Ph.D. or her office to leave a detailed message at the following numbers:

○ _____ **Home Phone**

○ _____ **Cell Phone**

○ _____ **Work Phone**

_____ _____

Signature **Date**