BRYN DUNGAN, PSYD, HSPP
Clinical Psychologist

2680 E Main Street, Suite 304
Plainfield, IN 46168
Tel: (317) 384-7196
Fax: (317) 203-7353

ADULT PATIENT REGISTRATION FORM

Name: | Date of Birth: | Age: | Today's Date:

Gender: | Preferred Gender Pronouns (if applicable):

Street Address: | City, State, Zip

Preferred Phone Number: | Email Address:

Doctor's Name and Phone Number:

Past Therapist Name and Phone Number:

Emergency Contact and Release of Information

Emergency Contact Name: | Emergency Contact Phone Number | Relationship

Please indicate if there is anyone you would like to have access to your Protected Health Information. This will only include basic information and if you would like more information to be released to anyone, a formal consent form will need to be completed. This section is most appropriate for parents/guardians, spouses, or significant others.

Name of person you would like information released to | Relationship to me | Phone Number

Address of person you would like information you would like released to

Please indicate the types of information you would like released to the above person

Billing

- ☐ Let them know about my outstanding bill
- ☐ Let them ask questions about insurance

Scheduling

- ☐ Allow them to know about my appointments
- ☐ Allow them to schedule appointments for me
- ☐ Allow them to change my appointments
- ☐ Allow them to know my attendance

Insurance and Payment Information

Insurance

Anthem BCBS

Insurance Phone Number

Policy holder's name

Policy holder's date of birth

Insurance ID

Group Number

Referral Information

Reason for referral

Presenting problems

How long have you been dealing with these problems?

List Current Medications you are prescribed and are taking

Please list any other important information

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Practice Agreement

Initial ☐ I have received/read the Office Polices and Patient Agreement that was emailed to me and I agree to it's terms. I have also received the HIPAA Notice of Privacy Practices.

Initial ☐ I authorize the release of any information required in the course of examination or treatment necessary to process an insurance claim, if I am using insurance. I also assign payment of insurance benefits to Dr. Dungan for the services rendered.

Initial ☐ I understand and agree that regardless of any insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees with collecting the bill.

Initial ☐ I understand that payment is due at the time of services unless other arrangements are made. No-show or cancellations within 24 hours of appointment time may result in a self-pay charge that will not be covered by insurance.

Initial ☐ I have read and agree to the terms of the Practice Agreement. I acknowledge that I am the Parent or Legal Guardian of the patient, and agree that my initials and signature at the end of this document is a legally binding equivalent of my handwritten signature.

Telepsychology Practice Agreement

Initial ☐ I have received/read the Office Polices and Patient Agreement for Telepsychology services that was emailed to me and I agree to it's terms. I have also received the HIPAA Notice of Privacy Practices.

Initial ☐ I authorize the release of any information required in the course of examination or treatment necessary to process an insurance claim, if I am using insurance. I also assign payment of insurance benefits to Dr. Dungan for the services rendered.

Initial ☐ I understand and agree that regardless of any insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees with collecting the bill.

Initial ☐ I understand that payment is due at the time of services unless other arrangements are made. No-show or cancellations within 24 hours of appointment time may result in a self-pay charge that will not be covered by insurance.

Initial ☐ I have read and agree to the terms of the Practice Agreement for Telepsychology services. I acknowledge that I am the Parent or Legal Guardian of the patient, and agree that my initials and signature at the end of this document is a legally binding equivalent of my handwritten signature.

Revised Supplemental Informed Consent for In-Office Visits During the Pandemic

I understand and agree to the following requirements to be seen during the pandemic:

Initial ☐ You will wear a cloth face covering or surgical face mask during all sessions and Dr. Dungan will do the same.

Initial ☐ You will only keep your in-person appointment if you are symptom free. If symptoms are present as outlined in the Revised Supplemental Informed Consent, the appointment will be canceled and moved to telepsychology if possible.

Initial ☐ You will wait in your car until your session time and not the waiting room. You will text Dr. Dungan at (317-384-7196) when you have arrived and Dr. Dungan will inform you when it is time to come to session.

Initial ☐ Parents with minors may not wait in the waiting room until the session is complete. They must wait in their car or outside of the building. They may text any concerns or come in at the end of session for any updates.

Initial ☐ Hand sanitizer will be available in Dr. Dungan's office.

Initial ☐ You will adhere to safe distancing precautions Dr. Dungan has outlined in the Revised Supplemental Informed Consent and posted on her office door. There will be no physical contact (i.e., hugs, handshakes) and you will sit where asked during session.

Initial ☐ You will notify Dr. Dungan of any potential exposure risks including jobs, or activities.

Payment Agreement

Dear Client/Responsible Party on Behalf of Client:

By signing and dating this form, you agree to be personally responsible for all charges incurred through the services provided by Dr. Dungan. This includes cost of intake, therapy sessions, testing sessions, no-show appointments, and late canceled appointments.

Payment for services is due at the time of service. For self-pay patients, the agreed upon amount is due at the time of service. For insurance-based patients, an estimated cost of service will be due at the time of service. These estimated costs will be explained in detail during the intake session. Additional fees will be incurred if there are no-show appointments or late canceled appointments. The fees for these missed appointments will be added to the amount due for both self-pay patients and insurance-based patients during the next session.

If you use insurance benefits, Dr. Dungan will attempt to verify your benefit coverage for her services to the best of her ability by contacting your insurance company. She needs to inform you; however, that benefit coverage does not guarantee payment by your insurance company. If coverage is denied by your insurance company, you will be personally responsible for all charges incurred by signing and dating this form.

If services are terminated and there is a remaining balance due, Dr. Dungan will attempt to contact you to collect payment. If she is unable to reach you after a reasonable period, she will charge the credit card on file to settle the balance.

By signing below, you agree to all terms and conditions outlined in this document. You acknowledge that you are the Parent/Legal Guardian of the patient, and understand that your signature is legally binding.

Client's name

Client's Date of Birth

Guardian's name (if applicable)

Today's Date

Signature of Client/Legal Guardian