

**Orange County Health & Psychology Associates, Inc.**  
4482 Barranca Pkwy, Ste 130 Irvine, CA 92604  
2101 E. 4<sup>th</sup> St. Ste 100A Santa Ana , CA 92705  
Tel (949) 551-4272 & 949-551-2969, Fax (949) 551-6406  
www.ochpa.com

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**FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS**

The undersigned, whether they sign as an agent or as a patient, hereby agrees to pay the account in accordance with regular rates and terms of the Psychotherapy services rendered to the patient by Orange County Health & Psychology Associates, Inc. Usually, insurance does not take responsibility for no shows or cancellations, therefore the patient is responsible for such fees. An approximate hourly fee for services rendered is **\$150.00**. Cancellation fees within 24 to 48 hours before the appointment are **\$50.00**. No show and cancellation fees within 24 hours are **\$80.00**. A clarification phone conversation between appointments is free. For more than one interval phone conversation, phone appointment, and requests for copies of medical records there is a fee of **\$35.00**. Initial: \_\_\_\_\_

OCHPA will send these claims to your insurance company but any denied claims, or claims still unpaid after 90 DAYS, will be the patient's responsibility and OCHPA reserves the right to charge your Credit Card. Initial: \_\_\_\_\_

Should the account be referred to an attorney and/or for collections, the undersigned hereby agrees to pay reasonable attorney fees and /or collection expenses. The undersigned accepts terms hereof, certifies that he or she has read the forgoing, and is the patient or is authorized to sign as the patient's agent. Initial: \_\_\_\_\_

I have read and understood the Cancellation/Missed Appointment and the Denied Claim Policy listed above.

Please let us know if you have any questions or concerns.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Guardian or  
Responsible Person: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I authorize my credit card to be charged for the aforementioned services, cancelled/missed appointments, and/or claims that are denied or not covered by my insurance.**

Card type: \_\_\_\_\_ Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name and Address of card holder: \_\_\_\_\_

Addresses \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**CONFIDENTIALITY:** I understand that all information shared between my therapist and myself is held strictly confidential unless:

1. I authorize a release of information with my signature
2. I present a danger to myself
3. I present a danger to others
4. Child/Elder abuse/neglect suspended

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

**RELEASE OF INFORMATION:** In addition to releases of information permitted above, I authorize discussion of my case with my insurance carrier(s) and psychiatrist/primary care physician for the purpose of diagnosis and treatment. I further authorize the release of written and verbal information regarding my treatment for authorization, claims, certification, case facilitation, quality improvement, and other purposes related to the benefits of my health plan to my insurance carrier(s). \_\_\_\_\_ . (Initial)

(Releases of information to places of employment, schools, family, etc. require a separate written and signed release form).

**FINANCIAL TERMS:** OCHPA will verify and bill my insurance if they have a contractual agreement with my insurance company and OCHPA will be paid directly by the insurance company. I will be responsible for any deductibles or co-payments at the time of each visit. If I am not eligible for any reason at the time services are rendered, I will be 100% responsible for the payment. Payments for Biofeedback, Neurofeedback, Brain Mapping, and/or group therapy are due at time of visit. If I am without health plan coverage, payment arrangements will be made prior to my visit. If I become over ninety days delinquent by not paying any balance, I understand my account and the breakdown of charges may be sent to a collection agency. \_\_\_\_\_ . (Initial)

**CANCELLED/MISSED APPOINTMENT POLICY:** A scheduled appointment means that time is reserved only for me. I will call OCHPA 48 hours prior to a scheduled appointment in the event I need to cancel. A message may be left at 949-551-4272 if the office is closed. I am responsible for any appointment time and I understand that I will be charged a fee for my missed session if I am late, cancel, or do not show up and that my insurance provider does not cover now show or late cancellation charges. I understand and agree that the fees charged for no shows and late cancellations are as follows: cancellation fees within 24 to 48 hours before the appointment are **\$50.00**. No show and cancellation fees within 24 hours are **\$80.00**.

GRIEVANCES: I acknowledge that I may submit a grievance to the Clinical Director of OCHPA at any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit the Grievance to the director office for civil rights of the U.S. Department of Health and Human Services. Upon request, our office will provide you with the current company directly. I may also contact the California Department of Managed Care and use the appeals and grievance process.

EMERGENCY PROCEDURES: If I need to contact my therapist after regular business hours, I will call 949-551-4272 and leave a message at the voice mail. If it is a true emergency, I need to go to a local emergency clinic. I understand that I may be charged for a telephone consultation.

CONSENT FOR TREATMENT: I further authorize and request that OCHPA and my therapist carry out psychological examinations, treatments, and/or diagnostic procedures which are advisable during the course of my care. I understand that the purpose of these procedures will be explained to me upon my request and will be subject to my agreement I also acknowledge that I may refuse treatment at any time.

***For child clients only***: By initialing this section and signing below I am declaring that I have the full legal right to authorize consent to the treatment of my child or that this treatment has been discussed and approved by all parties that share legal custody. \_\_\_\_\_ (Initials)

QUALITY IMPROVEMENT & SATISFACTION SURVEYS: To maintain and enhance the quality of the services OCHPA provides, I will occasionally be asked for my input regarding the care I receive. OCHPA values these opinions and will keep all information confidential. When I am asked about my thoughts during the course of your treatment, I will provide OCHPA with an honest evaluation of the services I have received (this information may be used for outcome studies, and the results may be obtained upon request once the study is completed).

SOLUTION-FOCUSED THERAPY: My insurance company plan usually pays for treatment using solution focused philosophy. The treatment is goal oriented. Problem focused and based on realistic, measurable objectives. Treatment emphasizes the reduction of symptoms that are causing distress and an impairment of social and/or occupational functioning. I understand that I am expected to collaborate in the process of goal setting, homework assignments, and skill development.

**I understand and agree to all of the above information.**

\_\_\_\_\_  
CLIENT/LEGAL GUARDIAN NAME: PRINTED

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CLIENT/LEGAL GUARDIAN NAME: SIGNATURE

\_\_\_\_\_  
THERAPIST SIGNATURE