Kathleen Cramer, Ph.D.
Patient Identification Form and Financial Responsibility Acknowledgment

Patient Name (Last, First, Middle): _____

Date of Birth: _____ (Check One): ☐ Male ☐ Female

Address: _____
Street Address Apt # (if applicable) City State Zip

Phone: _____ Parent/Legal Guardian (if applicable): _____

Address: _____
Street City State/Zip

In case of a medical emergency or any other emergency, please list two emergency contacts below:

Name: _____ Telephone Number: _____

Name: _____ Telephone Number: _____

If patient is under the age of eighteen (18), please list the name(s) of individuals to whom the child may be released:

_____ _____

_____ _____

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT:

I acknowledge full financial responsibility for services rendered by KATHLEEN CRAMER, PH.D. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to KATHLEEN CRAMER, PH.D. should they elect to receive such payment.

I understand that KATHLEEN CRAMER, PH.D. verifies my mental health benefits through my insurance as a *courtesy* to me. I further understand that it is my responsibility to ensure services are covered and/or what my exact benefits are, not KATHLEEN CRAMER, PH.D. KATHLEEN CRAMER, PH.D. will assist me in this process to the best of its ability. I understand that I am ultimately responsible for payment of all services rendered. I understand that any co-pays, deductibles, or any other payments of outstanding balances are due prior to services being rendered. I understand that it is my responsibility to update KATHLEEN CRAMER, PH.D. of any changes in insurance.

I understand that my health insurance is a contract between me and the insurance company and/or my employer, not KATHLEEN CRAMER, PH.D. If there are any disputes of benefit coverage, I understand that I need to contact my insurance carrier.

I have read and fully understand the above financial responsibility and insurance authorization.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
Printed Name of Patient/Parent/Legal Guardian