HICKS GROUP: WELLNESS CENTER

OFFICES OF AUNJULI HICKS, PHD

Name of Patient:_____ DOB:_____SS#:_____

Address:_____

Home #_____Work #_____Cell#_____Emergency Contact_____ Phone_____Email:_____

FAMILY MEMBERS

Name	Sex	DOB	Relationship

INSURANCE INFORMATION

Primary In. Co	**Secondary In.Co**
Address	Address
Telephone#	Telephone#
Ins. ID#	Ins. ID#
Group#	Group#
Insured Name	Insured Name
Insured DOB **Patient DOB**	Insured DOB Patient DOB
Ins.SSN# **Patient SSN#**	Ins.SSN# Patient SSN#
Employer Name	Employer Name
Employer Address	Employer Address

No Show Policy	No Call or Call on the Day of Appointment. Or Not showing at all	Fee: $300 not covered by health plan must be paid by the patient
Cancellation Policy	Call between 24-96 hours	Fee: $45
Late Policy	15 minutes late 30 minutes late 50 minutes late	Fee: 15%=$45 Fee: 30%=$90 Fee: 50%=$300
Paperwork	Letters FMLA Forms Reports	Fee: $10-15 Fee: $35 Fee: $250-$600 (depends on report)

ASSIGNEMENTS OF BENEFITS: MEDICAL BENEFITSDIRECTION TO AUNJULI HICKS, LPC LLC/HICKS GROUP: WELLNESS CENTER/ ASSOCIATES FOR SERVICES PROVIDED I REQUEST THAT PAYMENT OF AUTHROIZED BENEFITSBE MADE TO AUNJULI HICKS LPC LLC/HICKS GROUP WELLNESS CENTER/ASSOCIATES FOR ALL SERVICES FURNIHSED TO ME BY AUNJULI HICKS LPC LLC/HICKS GROUP WELLNESS CENTER/ASSOCIATES **PRINT**_____**SIGN**_____**DATE**_____