

JEFFREY L. MAHLER, Ph.D.

Licensed Psychologist

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Evergreen, CO 80437
(303) 670-4280

PERSONAL INFORMATION

Name of Client _____
Date of Birth _____ Social Security # _____

Responsible Party _____
Mailing Address _____

Home Phone(s) _____ Work Phone(s) _____ (self)
Mobile Phone(s) _____ (self) _____ (spouse or relative)

In Case of Emergency, Please Contact _____
Emergency Phone _____

Referred By _____

Brief Statement of the Problem(s) _____

Initial Goals for Treatment _____

School Name, Address & Phone (*Complete If Client Is Under Age of 18*)

School Contact Person _____

INSURANCE REIMBURSEMENT POLICY

Dr. Mahler is a provider for many major insurance companies. **It is the responsibility of the client or policyholder to verify their benefits and to determine what out of pocket costs are applicable. Dr. Mahler and his billing personnel will confirm benefits, but are not responsible for determining the costs not covered by the insurance company unless specified in the provider agreement. At the time of the first session, a \$150.00 deposit is required that will be applied to all out of pocket or co-pay fees not covered by insurance.** When billing questions arise, Dr. Mahler will inform the client of the situation and ask them to work with the insurance carrier to resolve any disputes. If you change insurance carriers during a course of treatment, you are responsible for notifying Dr. Mahler within 30 days of the change and verifying benefits on the new plan. Failure to notify Dr. Mahler in a timely manner will result in the client being responsible for any services not covered during the transitional period.

I have read the above policy on insurance coverage and agree to abide by the conditions as stated above. I also agree that Dr. Mahler may release requested information about myself or my child to the above listed insurance company necessary for reimbursement for services.

Parent or Client Signature _____ Date _____ Witness _____ Date _____