DEISY CRISTINA BOSCAN, PHD., A PROFESSIONAL CORPORATION

7590 Fay Ave Suite #401 La Jolla, CA 92037

PHONE: 858-263-4226 – 858-263-4206

FINANCIAL RESPONSIBILITY

RESPONSIBLE PARTY'S INFORMATION (If different from patient)

Responsible Party's Name:	**Relationship to Patient:**	
Date of Birth: *(MM/DD/YYYY)*	**Social Security:**	
Responsible Party's Address:	**City, State, Zip:**	
Home Phone:	***Message Ok?*** ☐Yes ☐No	**Marital Status:** ☐Married ☐Single ☐Widowed ☐Separated ☐Divorced
Work Phone:	***Message Ok?*** ☐Yes ☐No	
Cell Phone:	***Message Ok?*** ☐Yes ☐No	

FEE AGREEMENT

I understand the above charges for services and agree to assume responsibility for all charges rendered for myself or my child's care. I understand that for Dr. Boscán I will provide insurance documentation to my insurance company to help with the coverage of all or part of any balance owed to her. I also understand that an appointment commits the doctor's time to me (or my child) and unless a minimum of a 48-hour advance notice is given, I am financially responsible for all cancelled or missed appointments. I agreed to pay all fees which are not covered by my insurance company, and to hold Dr. Boscán harmless for any legal claim made by myself or others for non-payment of her fees, my insurance company or other third-party payer. I understand that my account could be transferred to a collection agency for non-payment of fees. If the account is not paid in full in 60 days from the date of service, the balance will begin accruing interest which will be added to the balance due. I authorize the release of information necessary to process insurance claims and assign my benefits directly to Dr. Boscan. I agree to pay my full balance, full co-payment, or fee of _____.

Client's Printed Name	Client's / Parent's / Guardian Signature	Date
_____	_____	_____

INSURANCE INFORMATION

Please provide copies of all ID cards – front and back if applicable. Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or a third-party payer. It is your responsibility to know if this is true. ***ALSO BE AWARE THAT I ONLY ACCEPT PPOs AND TRICARE****.*

☐ **Please check here if you have no insurance and you will be solely responsible for payment.**

Primary Insurance Company Name:	**Claims Address:**	**City, State, Zip:**
Subscriber's Name:	☐ **M** ☐ **F** **Date of Birth:**	**Group #:**
Subscriber's ID#:	**Subscriber's Social Security:**	**$ Co-Payment:**
Subscriber's Employer:	**Relationship of Patient to Subscriber:** ☐Self ☐Spouse ☐Child ☐Parent ☐Other:	
Patient's Signature:		**Date:**
Responsible Party's Signature:		**Date:**

Please note: *Late Cancellations and No-Show Policies:* Please provide at least a 48-hour cancellation notice if you need to cancel or reschedule your appointment. Missed appointments and late cancellations, without a 48-hour notice, will be subject to a cancellation fee. *Office Policy:* Psychological Services are _____ billed per hour and automatically charged via credit card at the end of the month for services rendered. Statements will be provided per direct request. Psychological Assessments are billed per hour unless other arrangements have been made. Payment for services rendered is expected in full before the release of the psychological report.