Jon Skidmore, Psy. D.
Licensed Psychologist/Performance Coach
And Associates
276 E. 950 S. Orem, Utah 84058
801-426-2685
Fax 866-356-2518

Client

Last Name		First Name		M I
Street Address			City	State Zip
Marital Status	Sex	Age	Date of Birth	Home Phone
Social Security #	Employer / School	Cell Phone		Work Phone
	Your email address:			

Wife / *Mother / *Guardian (* Information required for all minors)

Last Name		First Name		M I
Street Address			City	State Zip
Marital Status	Relationship	Date of Birth		Home Phone
Employer		Cell Phone		Work Phone

Husband / *Father / *Guardian (* Information required for all minors)

Last Name		First Name		M I
Street Address			City	State Zip
Marital Status	Relationship	Date of Birth		Home Phone
Employer		cell phone		Work Phone

Jon Skidmore, Psy. D. Licensed Psychologist

Primary insurance

Name of Insurance Company		Insurance Company Phone
Address of Insurance Company		Policyholder's Relationship to Patient
Policyholder's Name		Policyholder's Date of Birth
Policyholder's Social Security Number	Policy Number	Group Number
Policyholder's Employer		Work Phone

Nearest relative not living with you

Full Name	Relationship to Patient
Address	Home Phone

Who referred you to see Dr. Skidmore? _____

Who is the patient's primary care physician? _____

Can Dr. Skidmore release and obtain confidential information from your primary care physician? If YES, please sign below: (Release of Information is valid for six months from the date signed):
_____ Date: _____

Date of last physical examination: _____

Please indicate any health problems or allergies:
_____
_____
_____

Is the patient currently on any medication? If so, please write the names of the medications below:
_____

Briefly describe the reason why you are seeking help at this time:
_____
_____
_____
_____

Jon Skidmore, Psy. D. Licensed Psychologist

Payment Policy

I agree to be responsible for payment of this account. Payment in full is expected until insurance coverage and co-pays have been verified. Please make checks payable to Jon Skidmore and come prepared to make payment in-full or co-pays at the time of service.

I understand that a fee may be charged for telephone consultations, reports, reproduction of records, letters, correspondence, psychological testing and medical consultations.

In the event that Dr. Skidmore receives a subpoena on behalf of the patient, I agree to pay his expert witness fee.

I understand that failure to cancel an appointment 24 hours before it is scheduled or missing an appointment may result in a missed appointment fee of $95.00.

I recognize that Dr. Skidmore cannot accept responsibility for collecting an insurance claim or negotiating any settlement on a disputed claim. In the event of default in the payment of any amount due, I agree to pay all cost of collections including an added charge of 50% to the account balance and any additional attorney fees and court costs incurred as permitted by the laws governing these transactions. Please acknowledge with your initials _____.

A finance charge of 1.5 percent per month (annual rate of 18 percent) may be charged on all balances over 30 days, regardless of pending insurance claims. Outstanding balances older than 90 days are considered delinquent and may be turned over to a collection agency.

If there are any questions or concerns regarding billing, receipt of insurance payments or the payment of your outstanding balance, please talk to Leanna at Progressive Billing 801-354-7815.

Confidential Information Policy

Dr. Skidmore and Associates follow the HIPPA guidelines for the protection of confidential information. (____) My initials acknowledge that I have received a copy of the HIPPA guidelines.

FEE SCHEDULE

Initial Evaluation	$170.00
Expert Witness Fee	$170.00
53-65 Minute Therapy/Consultation	$135.00
40-50 Minute Therapy/Consultation	$110.00
20-35 Minute Therapy/Consultation	$70.00
Group Therapy	$65.00
Missed Appointment	$95.00
Late Cancellation (Less than 24 hours)	$95.00
Returned Check Fee	$25.00

Signed by Client or Guarantor: _____ Date: _____