Brad K. Greenspan, MD

480 Elm Place, Suite 104
Telephone 847-748-8740
www.bradgreenspanmd.com

Highland Park, IL 60035
Fax 847-221-6898
psychiatry@bradgreenspanmd.com

PATIENT INFORMATION

Please provide mailing and telephone numbers where we can reach you without breaching confidentiality.

Name_____
Last First M.I.

Address_____ City_____ State___ Zip_____

Home Phone No._____ Birthdate_____/_____/_____ Age_____

Cell Phone No._____ Email_____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

How did you hear about our practice?_____

Guarantor Information

If you wish to have the office of Dr. Greenspan bill a third party please complete the following information. You are ultimately responsible for all charges regardless of the information you provide.

Person responsible for account_____ Relationship_____
Last First M.I.

Address_____ City_____ State_____ Zip_____

Credit Card Information

Subscriber Name_____ ☐ **VISA** or ☐ **MasterCard**

Card No. _____ Sec. Code_____ Expiration Date _____

Dr. Greenspan may charge to my credit card any balance greater than 61 days. Failure to pay my outstanding balance may result in my account being sent to collection. I agree that I shall owe the outstanding balance plus all collection fees, including attorney's fees and court costs.

Payment Agreement

I understand that payment is expected at the time of service. Cash, check, ApplePay, GooglePay, and most major credit cards are accepted as forms of payment. I understand that charges incurred as a result of my treatment are my obligation. Payments made by an insurance company do not relieve me of this obligation. Payments not received within 30 days of receipt of an invoice will result in a $20.00 late fee. **I further understand that a *twenty-four hour (one business day)* notice is required to cancel an appointment** and that **failure to cancel within this time frame will subject me to a "*Late Cancellation*" charge (100%). I also understand that failure to keep an appointment without prior cancellation will subject me to a "*No Show*" charge (100%).**

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above plan(s) and assign directly to Brad Greenspan, MD all insurance benefits, if any, otherwise payable to me, for services rendered. Further, I authorize Brad Greenspan, MD to charge to the above credit card any unpaid balance after 61 days. The office of Dr. Greenspan will make a reasonable effort to contact me prior to applying the charges to give me an opportunity to remit payment in full using an alternate method.

I hereby authorize Brad K. Greenspan, MD to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and any credit card billing.

Responsible Party Signature_____ Date_____

Patient (if 12-18 years of age)_____ Date_____