MICHAEL N. GARCIA, L.P.C.

CONFIDENTIAL CHILD PATIENT REGISTRATION

PATIENT

Full name_____Date of birth_____

Address_____

_____Phone_____

RESPONSIBLE PARTY

Full name_____Date of birth_____

Address_____

_____Phone_____

Email_____

Relationship to patient_____

BILLING An invoice will be provided at the end of each month. Payments are due within the following 30 days.

SUBMITTING INVOICES TO INSURANCE If submitting invoices to insurance for out-of-network benefits, patients and responsible parties are required to pay fees to my office within 30 days of receiving the invoice, regardless of insurance contributions. Insurance companies require that a valid invoice include an identified patient with a mental health diagnosis code, which I can provide. Please be aware that the diagnosis becomes part of the official medical record on file with the insurance company.

RESCHEDULING AND CANCELLATIONS If you must cancel or reschedule your appointment, please allow me 24 hours or more of advanced notice to make appropriate arrangements to my schedule. Without 24 hours of notice to cancel a session, it is my policy to charge for my time. Whenever possible, it is important to make up missed sessions to preserve an ongoing momentum in the treatment.

LOCATION My consulting room is located next to my home in Charlottesville. It is most helpful if you arrive on time or no earlier than 5 minutes prior to your appointment. Also, please leave the parking space available immediately following your appointment. The waiting area is located just in the front door to the office. I will come find your child at the hour of the appointment.

Patient/ Parent/ Legal Guardian Date

+1.434.981.7249
www.michaelgarcialpc.com