Richard D. Recor, Ph.D.
TELEHEALTH SERVICES

(949) 720-0167
www.DrRecor.com

ADULT PERSONAL HISTORY FORM

Name_____ Date:_____

Gender ___M ___ F Date of Birth: _____ Age: _____ Social Security No: _____

_____
Address City State Zip Code

_____ _____ _____
Home Phone Cell Phone Work Phone

E-Mail Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Ethnicity: _____ Family Size: _____

Referral Source(s): _____

Occupation: _____ Education level: _____

Current Employment Status: _____ Unemployed _____ Part Time _____ Full Time

Current Employer: _____

Marital Status: _____ Single _____ Married (how long) _____ _____ Separated (how long) _____

_____ Unmarried, living together (how long) _____ _____ Widowed (how long) _____

_____ Divorced (how long) _____ Total Number of Marriages _____

Assessment of current relationship (if applicable): _____ good _____ fair _____ poor

Primary reason(s) for seeking services:

___ Anger management ___ Anxiety ___ Addictive behaviors ___ Alcohol/Drugs
___ Eating disorders ___Fear/phobias ___ Coping ___ Depression
___Sleeping problems ___Mental Confusion ___Sexual Concerns ___ Other (specify)
_____

Do you feel suicidal at this time: ___ Yes ___ No

If yes, explain: _____
_____

Please check behaviors and symptoms that occur to you more than you would like them to take place:

____ Aggression	____ Dizziness	____ Irritability	____ Sleeping Problems
____ Alcohol Dependence	____ Drug Dependence	____ Judgment Errors	____ Speech Problems
____ Anger	____ Eating Disorder	____ Loneliness	____ Suicidal Thoughts
____ Antisocial Behavior	____ Elevated Mood	____ Memory Impairment	____ Thoughts Disorganized
____ Anxiety	____ Fatigue	____ Mood Shifts	____ Trembling
____ Avoiding people	____ Gambling	____ Panic Attacks	____ Withdrawing
____ Chest Pain	____ Hallucinations	____ Phobias/Fears	____ Worrying
____ Computer/Internet Addiction	____ Heart Palpitations	____ Recurring Thoughts	____ Other (Specify below)
____ Depression	____ High Blood Pressure	____ Sexual Addictions	_____
____ Disorientation	____ Hopelessness	____ Sexual Difficulties	_____
____ Distractibility	____ Impulsivity	____ Sick Often	_____

What are your goals for therapy? _____

_____

_____

_____

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	No	Yes	When	Where	Reason
Counseling/Psychiatric Treatment					
Suicidal Thoughts/Attempts					
Drug/Alcohol Treatment					
Hospitalizations					
Involvement with self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)					

FAMILY INFORMATION

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

Information about family/significant others (past and present):

	No	Yes	Who	When	Reason
Counseling/Psychiatric Treatment					
Suicidal Thoughts/Attempts					
Drug/Alcohol Treatment					
Hospitalizations					
Involvement with self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)					

MEDICAL /PHYSICAL HEALTH

Check all that apply:

____ AIDS/HIV	____ Constipation	____ Hepatitis	____ Sore Throat
____ Alcoholism	____ Chicken Pox	____ High Blood Pressure	____ Scarlet Fever
____ Abdominal Pain	____ Dental Problems	____ Kidney Problems	____ Sinusitis
____ Abortion	____ Diabetes	____ Measles	____ Small Pox
____ Allergies	____ Diarrhea	____ Mononucleosis	____ Stroke
____ Anemia	____ Dizziness	____ Mumps	____ Sexual Problems
____ Appendicitis	____ Drug Abuse	____ Menstrual Pain	____ Tonsillitis
____ Arthritis	____ Epilepsy	____ Miscarriages	____ Tuberculosis
____ Asthma	____ Ear Infections	____ Neurological Disorders	____ Toothache
____ Bronchitis	____ Eating Problems	____ Nausea	____ Thyroid Problems
____ Bed Wetting	____ Fainting	____ Nose Bleeds	____ Vision Problems
____ Cancer	____ Fatigue	____ Pneumonia	____ Vomiting
____ Chest Pain	____ Frequent Urination	____ Rheumatic Fever	____ Whooping Cough
____ Chronic Pain	____ Headaches	____ Sexually Transmitted Diseases	____ Other (describe)
____ Colds/Coughs	____ Hearing Problems	____ Sleeping Disorders	_____

List any current health concerns: _____

List any recent health or physical changes: _____

Medical Doctor: _____

Psychiatrist/Therapist: _____

Current Prescribed Medications	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Over-the-counter Meds	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ___ No ___ Yes (describe): _____

Please check if there have been any recent changes in the following:

____ Sleep Pattern	____ Eating Patterns	____ Behavior	____ Energy Level
____ Physical Activity Level	____ General Disposition	____ Weight	____ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

CHEMICAL USE HISTORY

Type of Drug	Quantity/Amount	Frequency of Use	Age of First Use	Used in Last 48 Hours		Used in Last 30 Days	
				Yes	No	Yes	No
Alcohol							
Barbiturates							
Valium/Librium							
Cocaine/Crack							
Heroin/Opiates							
Marijuana							
PCP/LSD/Mescaline							
Inhalants							
Caffeine							
Nicotine							
Over-The-Counter							
Prescription Drugs							
Other Drugs							

Substance of preference:
1. _____ 2. _____

Describe when and where you typically use substances _____
_____

Describe any changes in your use patterns _____
_____

Describe how your use has affected your family or friends (include their perceptions of your use) _____
_____
_____

Reason(s) for use:
____ Addicted ____ Build Confidence ____ Escape ____ Self-medication
____ Socialization ____ Taste ____ Other (specify) _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol?
____ No _____ Yes (describe) _____

Have you had any adverse reactions or overdose to drugs or alcohol? (describe) _____
_____

Have drugs or alcohol created a problem for your job? ____ No _____ Yes (describe) _____

_____

Does (has) someone in your family (present/past) have (had) a problem with drugs or alcohol?

___ No ____ Yes (describe) _____

LEGAL

Current Status

Are you involved in any active or prior cases (traffic, civil, criminal, child protective services)? ____ No ____ Yes
If yes, please describe and indicate the court and hearing/trial dates and charges _____

_____

_____

Are you presently on probation or parole ____ No ____ Yes
If yes, please describe _____
_____

Past History

Criminal involvement: ____ No ____ Yes DWI, DUI, Etc.: ____ No ____ Yes
Civil involvement: ____ No ____ Yes

If you responded Yes to any of the above, please complete the following information:

Charges	Date	Where (City)	Results

MILITARY

Military Experience: ____ No ____ Yes Combat Experience: ____ No ____ Yes Where: _____
Issues pertaining to Military experience? ___ No ___ Yes (describe)
_____
_____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ____ Not ____ Little ____ Moderate ____ Much
Are you affiliated with a spiritual or religious group? ____ No ____ Yes (describe) _____
_____
Were you raised within a spiritual or religious group? ____ No ____ Yes (describe) _____
_____
Additional Religious Issues/Experiences? ____ No ____ Yes (describe)
_____
_____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply):

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue Often ____ Follower
____ Friendly ____ Leader ____ Outgoing ____ Shy/Withdrawn ____ Submissive
____ Other (specify) _____
_____
_____

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? ____ No ____ Yes
If yes, were you a victim of child abuse? ____ Sexual ____ Physical ____ Verbal
Other childhood issues: ____ Neglect ____ Inadequate Nutrition ____ Other (specify) _____
Comments re: Childhood development: _____
_____
_____
_____
_____

Any additional information you would like to note:
_____
_____
_____
_____
_____
_____

Adult Consent for Treatment

I _____ authorize and request treatments that are advisable now or during the course of my care as a patient of Richard D. Recor, Ph.D., Licensed Psychologist.

I understand that the purpose of any treatment and/or procedure will be explained to me and be subject to my agreement.

I further agree that I have read and fully understand the attached Patient Consent and Rights Form.

_____

Patient Signatur Date

REQUIRED INFORMED CONSENT FOR TELE-HEALTH SERVICES IN PSYCHOLOGY

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of patient consent and rights, this document is required as part of your medical record. In addition, Dr. Recor feels providing this information to you in advance of your receiving services will clarify our office policies and alleviate any misunderstanding regarding what you should expect from us and what we expect from you. If you have any questions, please do not hesitate to contact Anita, Office Manager, (949) 720-0167.

Confidentiality: All aspects of services provided to you are held in the strictest confidence, in accordance with legal and ethical practice. Generally, no information will be released without your signed consent (or the consent of a legal guardian regarding a minor child in treatment). However, there are some situations in which we are required to break confidentiality. These situations are: suspected abuse of a child or elderly individual, imminent threat of harm to yourself or identifiable others, or when a court of law orders disclosure of the clinical record. When mental health is raised as an issue by a patient, in a legal proceeding, all confidentiality is waived. A written comprehensive Notice of Psychological Policies and Practices to Protect the Privacy of Your Patient Health Information is available upon request. Please discuss any concerns you have about confidentiality with Dr. Recor at the initial session.

Psychotherapy: Psychotherapy is a unique relationship between you (or your minor child) and Dr. Recor, in which you are provided with an environment for enhanced self-understanding. The process of psychotherapy works best if you are as open and honest about your thoughts and feelings as possible. A treatment plan will be implemented by yourself and Dr. Recor to assure working toward goals in treatment. If for any reason psychotherapy is not working for you, it is important to discuss this with Dr. Recor.

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology: Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks.

Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. By consenting to engage in telepsychology, you agree to seek emergency services via 911 or through the closest emergency room to you for any and all crisis situations that may arise during the course of our telepsychology work.

Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications: We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions: I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods should not be used if there is an emergency.
Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

Specific Telehealth Confidentiality: I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology: I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology: Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. (Complete the information at end of this consent).

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (949-720-1067). If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees: The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. (With the Covid-19 Virus Mandates as of 3/18/20 all telehealth services are covered by all insurance carriers until notified differently) *A credit card is required to be on file for any fee and/or co-payments due at the time of service (see Financially Responsible Party Form)

Records: The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I would maintain records of in-person sessions in accordance with my policies.

***REQUIRED INFORMATION IN ORDER TO PROVIDE TELEHEALTH SERVICES**

*Emergency Contact near you:_____
Emergency Contact Phone #_____
Relationship to Emergency Contact_____

I hereby certify that I have read and understand the contents of this document and will abide by the contents contained herewith. The original signed document will be retained as a part of the medical record and a copy of this signed document will be provided to you upon request per HIPAA requirements. Your signature below indicates agreement with all terms and conditions stated in this Consent for Tele-Health Services in Psychology with Richard D. Recor, Ph.D.

_____ _____
Patient Signature Date
(If patient is a Minor - both parents required to sign)

(electronically signed)_____ _____
Richard D. Recor, Ph.D. Date

REQUIRED CREDIT CARD ON FILE FOR ALL TELE-HEALTH SERVICES
Financially Responsible Party Information

Dr. Recor is committed to providing caring and professional mental health care to all his patients both in person and via tele-health.

As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers as further described in the Patient Consent and Rights Form. The financial policy is designed to clarify the payment policies as determined by the management of Richard D. Recor, Ph.D.

Your insurance policy, if any, is a contract between you and the insurance company, we are not part of the contract with you and your insurance company. As a service to you, we will only bill the insurance companies where Dr. Recor is a contracted provider,but cannot guarantee such benefits or the amounts covered and are not ultimately responsible for the collection of such payments. Any person with an insurance company that Dr. Recor is not contracted with will be handled as a self-payment account, a super-bill will be provided for your submission to your insurance company for any out of network benefits to be directly reimbursed to you. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. Dr. Recor charges the usual customary rates for these services provided in our area. Person Responsible for Payment of Account is responsible for payments of any insurance company's arbitrary determination of usual and customary rates or denial of payment for services.

The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 45 days. Payments not received after 60 days are subject to collections. A 15% interest fee effective the date the account became delinquent, as well as all collection fees associated in collecting the debt.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g. if there were previous visits to another mental health provider during the current benefit year), this amount will be collected by our office until the deductible payment is verified by the insurance company or third-party payer. Insurance benefits with contracted insurance companies will be assigned to Dr. Recor. All other insurance benefits will not be assigned to Dr. Recor and the Person Responsible for Payment of Account pays the entire balance each session.

Patients or their parent/legal guardian are responsible for payment at the time of service. Missed appointments or cancellations less than 48 hours prior to the appointment are charged the equivalent of a 60 minute therapy session and will need to be paid in full before another appointment can be scheduled. Questions regarding this agreement can be directed to either the Office Manager or Dr. Recor.

Requests for Letters/Reports for Non-Medical Purposes: The time involved in preparing such requests will be directly billed to you and is payable before release of such letter/report.
• I (we) have read, understand, and agree with the provisions of the Financially Responsible Party Information.

• Patient Name:_____
• Person (s) Responsible for Account:_____
• Person Responsible Address:_____

• Person Responsible Signature _____ Phone Number:_____

CREDIT CARD ON FILE REQUIRED IN ADVANCE OF ANY SERVICE VIA TELE-HEALTH SERVICES

• Preferred Payment Method: Visa MasterCard American Express

Credit Card:_____ Expiration Date: _____Sec Code:_____

Signature(s) of Authorized Credit Card Holder:

_____

Arbitration Agreement

This agreement made on _____between Richard D. Recor, Ph.D., Licensed Psychologist, hereinafter referred to as the "First Party" and

Patient/Parent/Legal Guardian Names: _____

Patient Name: -_____

Address: _____

Herein after referred to as "Second Party"

WHERAS, the business relationship between parties commenced _____ as defined in the original psychotherapy contract, namely Mental Health Services, which is attached and incorporated herein;

AND WHEREAS disputes and differences have arisen between parties;

AND WHEREAS the parties recognize that litigation in court can be time consuming and expensive;

AND WHEREAS the parties have appointed American Arbitration Association as their arbitrator.

NOW IT IS AGREED BETWEEN THE PARTIES HERETO AS FOLLOWS:

The parties hereto agree to the following matters and responsibilities to the Arbitrator:
Any controversy or claim arising out of or relating to this contract, or breach thereof, shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator)s) may be entered in any court having jurisdiction thereof.

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not be a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both partied to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

In the event of any dispute, claim, question, or disagreement arising from or relating to this agreement or the breach thereof, the parties hereto shall use their best efforts to settle the dispute, claim, question or disagreement. To this effect they shall consult and negotiate with each other in good faith and, recognizing their mutual interest, attempt to reach a just and equitable solution satisfactory to both parties. If they do not reach such solution within a period of 60 days, then, upon notice by either party to the other, all disputes, claims, questions, or differences shall be finally settled by arbitration administered by the American Arbitration Association in accordance with the provisions of its Commercial Arbitration Rules.

If a dispute arises out of or relates to this contract, or breach thereof, and if the dispute cannot be settled through negotiation, the parties agree to first try in good faith to settle the dispute by mediation administered by the American Arbitration Association under its Commercial Mediation Procedures before resorting to arbitration, litigation, or some other dispute resolution.

In the event there are any disputes or controversies that arise between the parties pursuant to the term is the aforesaid Contract, then the parties are waiving their rights to litigate these issues in court and instead elect to have these disputes resolved through arbitration.

The parties agree that any disputes are to be arbitrated through the American Arbitration Association and that the parties agree to abide by the rules of the Commercial Arbitration Rules of the American Arbitration Association.

WHEREFORE, it is agreed that all claims and disputes arising or relating to the Contract are to be settled by binding arbitration in the State of California. Said arbitration is to be resolved through Commercial Arbitration Rules of the American Arbitration Association and the parties agree to abide by these rules.

Any decision or award as a result of any such arbitration shall be issued in writing and the arbitrator shall be mutually selected pursuant to the Commercial Arbitration Rules or the American Arbitration Association. Any arbitration award may be confirmed in a court of competent jurisdiction.

The Agreement shall be signed by Richard D. Recor, Ph.D., Licensed Psychologist and by

_____, Parent(s) or Legal

Guardian(s) and/ or the patient on behalf of (Patient Name)_____.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Signature_____Date: _____
(Parent(s) /Legal Guardian(s) and/or Patient)

Signature:_____Date:_____
Richard D. Recor, Ph.D.

ASSIGNMENT OF INSURANCE BENEFITS

Patient Name:_____ Date of Birth: _____

Primary Insurance Co: _____

Name & Phone Number: _____
Mailing Address: _____

Policy Holder Name, Social Security # & Employer: _____
_____

Policy & Group #'s:_____
_
Secondary Insurance(If Applicable) _____

Name & Phone Number: _____

Claims Mailing Address: _____

Policy Holder Name, Social Security # : _____

Employer, Policy & Group #'s:_____

We suggest you confirm your insurance benefits with your insurance company(s) to assure your understanding of specific policy provisions. Your insurance Company may not pay for services they consider not medically or therapeutically necessary, or ineligible. If the insurance company(s)denies payment for any provided services, the Person Responsible for Account will be responsible for the balance of account.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my health care provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I _____ hereby authorize

_____
(Insurance Co. and/or third-party payer)

to pay and hereby assign directly to Richard D. Recor, Ph.D., all benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I also understand upon 60 days default, I am liable for any and all costs associated in the collection process of said debt as well as 15% interest on balance at time of default. I further acknowledge that any insurance benefits, will be credited to my account, in accordance with the above said assignment. In the event Dr. Recor is not a contracted provider with your specific insurance plan, this agreement is void and you will be given a superbill to submit for your direct reimbursement and assignment of benefits to our office does not apply. If you have any questions regarding insurance assignment please ask in advance of the service.

_____
Patient or Parent/Legal Guardian Signature Date