PERSONAL INFORMATION FORM

NAME: _____

DATE OF BIRTH: ___/___/___ OCCUPATION: _____

EMPLOYER: _____ BUSINESS PHONE : _____-_____-_____

HOME ADDRESS: _____

HOME CITY/STATE/ZIP: _____

HOME PHONE: _____-_____-_____ FAX : _____-_____-_____

EMAIL: _____ CELL: _____-_____-_____

NAME OF PERSONAL PHYSICIAN: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE: _____-_____-_____ FAX: _____-_____-_____

PLEASE SEND REPORT TO REFERRING PHYSICIAN (circle): YES / NO

SIGNATURE: _____ DATE: ___/___/___

I WILL BE PAYING TODAY BY (√):
CHECK: _____ CASH: _____ CREDIT CARD: _____

ALL BALANCES OVER 30 DAYS WILL BE BILLED TO YOUR CREDIT CARD, SO WE MUST HAVE THE FOLLOWING INFORMATION:

VISA: _____ MASTERCARD: _____ AMERICAN EXPRESS: _____

CARD #: _____ EXPIRATION DATE: ___/___/___

NAME (as it appears on card): _____

CARD ADDRESS _____
(Include street and zip code): CARD CODE (3 or 4 digits): _____

AUTHORIZING SIGNATURE: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

I understand and agree that, regardless of my insurance status, I am directly responsible for all professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers.

SIGNATURE : _____DATE: ___/___/___

FOR YOUR INFORMATION

ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept checks, cash and credit cards: American Express, Visa and MarsterCard. We will be happy to help you process your insurance claim for your reimbursement. We are unable to accept assignments and appointments cancelled without 24 hours notice. **Balances older than 30 days will be billed to your AmEx, Visa or Mastercard.**

We will gladly discuss your proposed treatment and answer any questions related to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

While our fees are generally considered to fall beyond the range that is fully covered by most insurance companies, we will work with you to ensure that you receive the maximum allowance as determined by your particular carrier.

We must emphasize that, as health care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date services are rendered.

SCHEDULE OF FEES

- **AEROSPACE PSYCHIATRIC ASSESSMENT (HIMS/FAA)**: $3,000
  Includes interview, review of Blue Ribbon file, medical review, psychiatry review, phone interactions with your AME/IMS, FAA and third parties regarding your case for that initial assessment

- **One-Time Psychiatric Consultation & Second Opinion**: $1,000

- **Executive Wellness Assessment (Lifestyle & Nutrition)**: $1,000

- **Follow-up**: $500/50 minutes

Please note, in-person meetings, report preparation for a third party, travel time on your behalf, missed appointments and telephone consultations are billed at $500 per hour. To cancel an appointment, please call 24 hours in advance. If you have any questions about this information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask. Also, please visit **www.ExecutiveWellness.com** for more information.