PATIENT INFORMATION RECORD

Name:______________________________ DOB:___/___/___ Age: _____ ___M ___ F
SSN:_______________ Driver's Lic#:______________ Marital Status: __S __M __D __Other
Street Address:____ Home Phone:____________
City:___________________________ State:______________ Zip:______________________

Emergency Contact:
Name:_________________________________ Street Address:_________________________
City & State:__________________ Phone:______________ Relationship to patient:_________
PATIENT EMPLOYER/SCHOOL ADDRESS: _____________________________________
PATIENT EMPLOYER/SCHOOL TELEPHONE:_____________________________________
PARENT/SPOUSE:_________________________ DOB:__/__/__ SSN:
PARENT/SPOUSE EMPLOYER ADDRESS:____
TELEPHONE:__________________________

May I leave a message for you to contact my office with someone at your home phone #?_______________

May I leave a message for you to contact my office on your home answering machine?______

1. PRIMARY INSURANCE:______________________________ I.D.#:__________________
Address:___________________________ City:______________ State:_______ Zip:________
Policy Holder:_________________________ DOB: ___/__/___ Group #:_________________
Relationship to Patient:____________________________

2. SECONDARY INSURANCE: __________________________I.D.#:___________________
Address:___________________________ City:______________ State:_______ Zip:________
Policy Holder:_________________________ DOB: ___/__/___ Group #:_________________
Relationship to Patient:____________________________

I hereby authorize JULIA BECKER, PSY.D, to furnish information to my insurance carriers concerning my illness and treatment. I hereby authorize JULIA BECKER, PSY.D, to provide treatment for me and/or my dependents.)

I authorize payment of medical benefits to JULIA BECKER, PSY.D.

DATE:______________________ SIGNATURE:______________________________

Please initial under each section:

Confidentiality:

I understand that my information and things I discuss with Dr. Becker will be kept confidential. I understand that there are exceptions to confidentiality, and confidentiality may be broken under any of the following circumstances:

1. If a court of law orders my records.
2. If Dr. Becker believes I am a danger to myself or someone else.
3. If I disclose sexual misconduct by a mental health therapist.
4. If Dr. Becker suspects child abuse or abuse of the elderly or disabled.
4. If I am using a mental health insurance policy, to pay for my visits, Dr. Becker will be required to provide certain diagnostic and basic treatment information in order to obtain payment for psychological services.

If you have any questions about the above information, or if you have questions about a specific situation, please feel free to discuss your questions with Dr. Becker.

****INITIALS: ________________**

Fees for services:

Fees for services are as follows:

Initial Evaluation	$160.00
Individual Psychotherapy	$125.00
Marital/Family Psychotherapy	$125.00
Psychological Testing (per hour)	$150.00

All fees are due after each session. Fees are assessed for each 50-minute session.

****INITIALS: __________________**

Court:

I understand that Dr. Becker does not testify in court as an expert witness. In rare and unusual situations where Dr. Becker might be required to testify in civil court, she will require payment of her standard fee of $125.00 per hour. Fees will be assessed for any time that Dr. Becker spends in court related activities. These include, but are not limited to, paperwork, consultation, travel, and time spent in court.

****INITIALS: __________________**

Crisis Intervention:

I understand that Dr. Becker does not provide 24-hour crisis counseling. If I experience a crisis that requires immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance. If I need to be seen prior to my next scheduled appointment, I understand that I may contact Dr. Becker and ask for an earlier appointment. I understand that Dr. Becker will make an effort but does not guarantee to provide me with an earlier appointment.

****INITIALS: _________________**

Additional Fees:

I understand that there is a $25 processing fee for returned checks. Additionally, I will need to make a cash or money order payment for the returned check and $25.00 processing fee. I understand that Dr. Becker may require cash payments for future sessions if a check is returned.

I understand that delinquent accounts may be turned over to a collections agency. Delinquent account activity includes, but is not limited to, unresolved returned checks, co-payments, and fees due if my insurance denies payment for your treatment. An account is considered delinquent when it is 30 days past due.

****INITIALS: ________________**

Cancellations:

I understand that Dr. Becker reserves my appointment hour for me. I understand that there is no fee to reschedule or cancel a session as long as I do so at least 24 hours in advance. If I do not cancel with 24 hours, the fee for calling to cancel on the day of my appointment is $50.00. Dr. Becker does make exceptions for emergencies.

I understand that if I do not show up for an appointment and do not call to cancel, I will be charged the full fee of $125 for the missed session. This fee is not covered by insurance. I understand that this will need to be paid before I schedule my next appointment.

****INITIALS: ______________________**

I acknowledge that I have read and understand the above information. I certify that the information I provided above is true and accurate, to the best of my knowledge. By signing below, I consent to receive psychological services from Dr. Becker. My signature also acknowledges that I have received a copy of Dr. Becker's Notice of Privacy Practices.

Printed Name ____________________________

Signature:_______________________________ Date:_______________________

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Patient Name:__________________________________

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "healthcare operations"). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise my Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of my Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or healthcare operations: however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my protected Health Information as specified above.

Signature of Patient:________________________________ Date:__________________