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Patient Information:

Name: Last: _____ First: _____

SS# _____ D.O.B. _____

Address _____ City _____ State _____ Zip _____

Telephone: (H) _____ (W) _____ (C) _____

Marital Status (circle) S M W Se D Spouse Name _____

PLEASE INDICATE IF MESSAGES CAN BE LEFT OR MAIL SENT

Home phone yes no
Work phone yes no

Cellular Phone yes no
Home Address yes no

Employer Name _____ Occupation _____

Street Address _____ City _____ State _____ Zip _____

Primary Care Physician

Name _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

Do we have your permission to coordinate care with your Primary Care Physician? yes no

Insurance:

Primary Policy

Name of Insured _____ SS# _____

Insurance Company _____ Policy # _____

Secondary Policy

Name of Insured _____ SS# _____

Insurance Company _____ Policy # _____

Emergency Contact:

Name _____ Phone _____ Relationship _____

Address _____

If under 18, legal guardian _____
(name, address, phone number)

Signature

Date

Appointments:

The normal practice's hours are (M-F 8:00am to 5:30 pm). Patients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency, your psychiatrist or therapist may be reached by answering service at (240) -638-9750. If you are unable to reach your psychiatrist or therapist, you may call your primary care physician or the local emergency room.

Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person or a disabled person, 2) when your psychiatrist or therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3) if you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4) if your psychiatrist or therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc. 5) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6) in natural disasters whereby protected records may become exposed or 7) when otherwise required by law. You may be asked to sign a Release of Information so that you therapist may speak with other mental health professionals or to family members.

Payments:

Payment is due at the time of the session unless other arrangements have been made. Your doctor will file you insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefit.

Cancellations and Missed Appointments:

You will be billed for a sessions that you cancel with less than 24 hours notice. You may leave messages 24 hours per day. You will be billed **\$35.00** not just a co-payment. Insurance companies do not reimburse for failed appointments.

Consent for Treatment

By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of patient or authorized person (please print)_____

Signature:_____

Date:_____

Office staff/Witness:_____