Barbara Baer, MSW, MPA, PhD

Patient Intake Form

Today's Date _____

Name_____ Birthdate_____

Home Address_____
(street, city, state, zip code)

Home Phone_____ Cell Phone_____

Relationship Status_____ # of children_____ Ages_____

Emergency Contact_____ Telephone_____

E-Mail Address_____

How were you referred to me?_____

Employer_____ Position_____

Company Address_____ Length of Time in Position_____

Business Phone_____ Ext. or Voice Mail #_____ Social Security #_____

Consent for Treatment
I provide consent for Dr. Barbara Baer to evaluate and treat me._____ _____
Signature of Patient Date

Privacy Statement: A statement of "Mental Health Privacy Rights" (see handout) has been made available to me.

____ Yes ____ No _____ (Signature)

Have you ever been in therapy before? _____ If so, when?_____

Have you ever been hospitalized? _____ For **medical** reasons? _____ When?_____ For What _____

_____

For **psychiatric** reasons?_____ When?_____ For what? _____

_____

Are you taking medication(s)?____ If so, what?_____

Do you have any allergies?____ If so, to what?_____

Do you smoke cigarettes?____ If so, how many/day?_____ If you stopped smoking, when?_____

Do you drink alcohol?____ If so, what do you drink?_____ Quantity?_____ Frequency?_____

Do you have **family members** who currently (or in the past) have a problem with use of alcohol or other drugs?

____Yes ____No If so, what relation to you?_____

Insurance Company_____ (I will need a copy of your insurance card)

Certificate #_____ Group #_____

RELEASE OF INFORMATION: I authorize the release of any information obtained during the course of evaluation or treatment of myself necessary to process insurance claims for payment for services rendered or to pursue collection of unpaid balance on my account.

Signature_____Date_____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Barbara Baer, PhD.

Signature_____ Date_____
(patient/authorized person)

Office Procedures and Fee Schedules

Fees are an important issue to anyone receiving professional services. Please review my fee schedule and let me know if you have questions/concerns.

$ 155.00	Diagnostic Assessment -	45-50 minute session (1st session)
$ 145.00	Individual Psychotherapy -	45 minute session
$ 145.00	Marital Psychotherapy -	45 minute session*

***(most insurance companies do not cover marital/couple's therapy)**

Statements: You will receive monthly statements and insurance claims will be filed at the beginning of the month following dates of treatment. When monthly statements are rendered, payment is expected within 10 days of receipt of the statement on any balance marked "due from you," unless prior payment arrangements have been made. Balances left unpaid for greater than 60 days may be subject to an interest charge of 1.5% per month. Balances left unpaid for greater than 90 days may be sent to a collection agency.

Insurance: As a general policy, I agree to help you use your insurance benefits by filing your claim to the insurance company and by accepting insurance assignments. Your signature (above) provides consent for me to release the necessary information to your insurance companies or other third party payers. Insurance cannot be billed without this consent.

Responsibility: You are responsible for payment of my professional fees. If a third party (such as your insurance company; another person/entity) fails to make timely payments, payment is expected from you. Insurance deductibles, co-payments and claims denied by insurance will be due from you. Payment is also due from you for services not covered by the insurance company (e.g., some treatment services; sessions not authorized when authorization is required by your insurance company; late canceled appointments).

CANCELLATION & MISSED APPOINTMENT POLICY: UNLESS YOUR APPOINTMENT IS CANCELLED WITH **24-HOUR-BUSINESS DAY NOTICE**, THE FULL FEE WILL BE CHARGED TO YOUR ACCOUNT. Insurance companies do not cover payment of these charges.

I am appreciative of the opportunity to be of service to you. If you have any questions, concerns or suggestions regarding any aspect of my practice, please discuss them with me. I am eager to receive your comments and will gladly answer your questions.

PROFESSIONAL AGREEMENT: I have read and understand the procedures and fee schedules described above.

_____ _____
Signature of patient/authorized person Date