PATIENT INFORMATION RECORD

Name:_____ DOB:___/___/___ Age: _____ ___M ___ F

Driver's License#:_____

Marital Status: __S __M __D __Other _____

Street Address:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Employer: _____

May I leave a message for you with someone at your home/cell phone? _____

Emergency Contact:

Name:_____Relationship:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Who is responsible for payment?

Name:_____Relationship:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

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.

SIGNATURE:_____ DATE:_____

Please initial under each section after reading it carefully:

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.
5. 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	$140.00
Marital/Family Psychotherapy	$140.00
Psychological Testing (per hour)	$150.00
Phone Consultation (15 minutes)	$40.00

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

****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 48 hours in advance. A late cancellation fee of $50.00 will be charged for all appointments cancelled with less than 48 hours notice.

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 $140 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: _____**

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:** _____

Court Testimony:

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 $140.00 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:** _____

Communication:

Telephone contact is the preferred method of communication. Email may also be used for routine non-clinical matters, such as rescheduling an appointment.

****INITIALS:** _____

Patient Certification:

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:_____

CREDIT CARD AUTHORIZATION FORM

I understand that my appointment time is reserved for me. I understand that I will be charged $140 if I fail to show up for my appointment, and will be charged $50 if I cancel my appointment less than 48 hours in advance of my appointment. I understand that these fees are not covered by my health insurance plan, and I am fully responsible for these payments. I authorize Julia Becker, Psy.D. to charge these fees to my credit card account specified below. I also authorize Julia Becker, Psy.D. to charge my card for any deductibles, coinsurance, and copayments that I may owe after my claim has been processed by my insurance company, as well as other charges not covered by insurance.

The undersigned card member consents and permits Julia Becker, Psy.D., as applicable, to charge to my credit card account specified below, or to any other credit card account of mine that I specify in the future, the amounts due from me for services provided to me and applicable fees during the applicable billing cycles. I release Julia Becker, Psy.D., as applicable, from any and all claims arising from the use of this service. I understand and agree that Julia Becker, Psy.D., as applicable, may continue to charge such amounts to my credit card account until receiving notification from me that I have withdrawn this consent and permission, at which time Julia Becker, Psy.D., as applicable, shall cease charging any such amounts to my credit card account.

Patient Name (Please Print)_____

Card Number _____ – _____ – _____ – _____

□ Visa □ MasterCard Expiration Date: _____ / _____
Month Year

Security Code (last three digits on back of card) _____

Card holder's name as shown on card _____

Card holder's billing address _____

City _____ State _____ Zip Code _____

Signature _____ Date _____

INFORMED CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Patient: _____

Name of Parent/Guardian (if under 18): _____

Phone number: _____

I, the undersigned, hereby authorize **Julia Becker, Psy.D**. to receive and disclose professional information to/from the following individuals or organizations:

_____ _____
Primary Care Physician or other referring professional Phone Number

_____ _____
Name of other individual/organization Phone Number

Such disclosure is limited to information relevant to the continuation of psychological care or assessment, and legal proceedings. This information may be disclosed orally, in writing, by email, or by fax.

_____
(Initials)

I understand that my records are protected by federal law (42 CFR part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it (i.e., information already disclosed). My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand. I further release Julia Becker, Psy.D., from any and all legal responsibility and liability that may arise from the act that I have hereby authorized.

_____
Signature of Patient or Parent/Guardian Date

_____
Signature of Witness Date