

Jeff M. Bauman, Psy.D., P.A. and Associates

Application for Services and Financial Policies-Adult Format

Date _____ Please tell us who referred you _____

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone# _____ Cell Phone# _____

Work Phone# _____

May we contact you by E-Mail? _____ If so, E-Mail address _____

Insurance I.D. : _____

Current Marital Status: _____ Years Married: _____

If Married: Spouse Name _____ Date of Birth: _____

Occupation: _____ Spouse Occupation _____

Place of Employment: Self _____ Spouse _____

Number of Marriages: _____ Number of Divorces: _____

Nearest Relative: _____ Phone# _____

Previous mental health professional/provider _____

Primary physician: _____ Phone: _____

Address _____ City: _____ Zip: _____

Please list chronic physical difficulties: _____

Current Medications:

Prescribed by:

What brings you in for treatment at this time?

How long have the difficulties been present? _____

What are your goals for treatment?

I hereby apply and consent to psychological services/consultation with Dr. Bauman and Associates. I understand that it is my responsibility to cooperate with treatment.

Signature _____ Date _____

Charges for services are due and payable at the time services are rendered. If you have health insurance, it should be understood that this is an agreement between you and your carrier. You remain directly responsible to the doctor for your account. If you fail to meet your financial responsibilities, we reserve the right to turn your account over to a collection agency or appropriate court.

I hereby give my consent to release necessary information for taking such action. I understand that I will be responsible for any expenses incurred due to collection or judicial actions in this regard.

Signature _____ Date _____

PLEASE BE SURE TO READ YOUR COPY OF PATIENT'S RIGHTS AND RESPONSIBILITIES! Please take it with you for your records.

I have read and understand the Patient's Rights and Responsibilities. I received a copy for my records.

Signature _____ Date _____

Please complete the following information as best you can. This allows for more efficient and effective use of your first session.

MY SYMPTOMS INCLUDE (Circle all that apply)

Depression Anxiety Insomnia Sadness Crying Spells
Suicidal Thoughts No pleasure No Energy Alcohol abuse Pain
Can't sit still Can't concentrate Can't Work Can't eat Eating too much
Sleeping too much Worrying too much Weight loss Weight gain Drug abuse
Headaches Troubling thoughts Feeling paranoid Feeling out of control
Thoughts to harm others Distrustful Fearful Confused or forgetful

Additional symptoms that are not mentioned _____

MEDICAL HISTORY (List all medical problems)

ALLERGIES: _____

MENTAL HEALTH HISTORY (Include dates/providers of any hospitalizations and outpatient treatment) _____

FAMILY MENTAL HEALTH HISTORY (Please list all blood relatives who have a documented or suspected psychiatric problem, including addictive disorders) _____

Has anyone in your family tried or successfully suicided? If so, who and when?

Have you ever tried to take your life? If so, how and when?

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HIPAA CONSENT

This form is an agreement between you and this practice. When we use the word “you” below, it can mean you, your, child, a relative, or other person if you have written his/her name here Patient Name)_____.

Your signature here certifies your consent that we may use/share your Protected Health Information as described in the HIPAA PRIVACY NOTICE you have received. Please make sure to read that document and ask us any questions.

After you have signed this consent, you have the right to revoke it (by writing a letter to Dr. Bauman). We will then comply with your wishes from that time forward. Of course we cannot do anything about information shared previous to your revocation.

Signature of patient or his/her personal representative Date

Printed name of patient or personal representative Date

Relationship to patient