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

Licensed Psychologist

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_____

Current Marital Status:_____ Years Married: _____

<u>If Married</u>: 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: _____

_____

<u>Current Medications:</u> **<u>Prescribed by:</u>**

_____

_____

_____

What brings you in for treatment at this time?

_____

_____

PATIENT NAME_____

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. 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. This practice does not bill nor interact directly with insurance companies. You remain directly responsible to the practice 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.

In the unlikely event that I do not meet my financial obligation, I hereby give my consent to release necessary information for taking collection action. I understand that I will be responsible for any expenses incurred due to collection or judicial actions in this regard.

Signature _____

Date _____

I understand that it is my responsibility to provide at least ***48 hours notice*** during business hours in order to cancel or reschedule an appointment. The practice will charge full fee for appointments cancelled or missed without this notice.

Signature_____

Date_____

PLEASE BE SURE TO READ YOUR COPY OF PATIENT'S RIGHTS AND RESPONSIBILITIES and HIPAA PRIVACY NOTICE! These are always available on our websites. WestonChildPsychologist.com or FloridaADHD.com

I have read and understand the Patient's Rights and Responsibilities-2018 and HIPAA.

Signature_____ Date_____

Print Name_____

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

Any other symptoms

_____

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?

_____

_____

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

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. Additionally I am asking your consent to communicate with the treatment team. This team consists of other healthcare professionals such as your pediatrician or psychiatrist during the treatment episode.

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