PATIENT INFORMATION

Name (Last, First) _____ Today's Date _____

Address _____ Date of Birth _____

City _____ Zip Code _____

Phone _____ Email _____

Employer / School _____ Grade _____

Emergency Contact _____ Phone _____

PRIMARY INSURANCE

Name of Subscriber _____ Date of Birth _____

Address _____ Subscriber's Employer _____

City _____ Zip Code _____

SECONDARY INSURANCE

Name of Subscriber _____ Date of Birth _____

Address _____ Subscriber's Employer _____

City _____ Zip Code _____

(For billing purposes only) Credit Card # _____

Exp. Date _____ CVV (no. on back) _____ ZIP Code (of cardholder) _____

Others living in your home, and their relationship to you:

_____

_____

_____

Referred by _____

Reason for referral _____

Other professionals consulted about this problem? (Circle one) **YES** **NO**

If **YES**, who? When? _____

Current Medications _____

_____

_____

Other Medical Conditions _____

_____

Additional information which may be helpful _____

_____

Please read and sign the reverse of this form

FINANCIAL AGREEMENT

Thank you for selecting **Deborah Baldwin, MS LPCC LCC** as your Mental Health Provider. I believe that it is important and necessary to explain my policy on handling insurance claims, co-payments, and payment for services. In accordance with insurance practices, it is the responsibility of the client to obtain prior authorization when necessary. It is the practitioner's responsibility to obtain additional authorizations when needed.

The standard fee for an initial assessment is **$150.00.** The fee for an individual session is **$125.00** and the fee for family sessions is **$150.00**. Co-payments are accepted in accordance with the terms of insurance policies. Co-payments and fees are due at the time of the appointment. Claims will be sent to the primary insurance carrier and the secondary insurance carrier, if there is one. Fees not covered by insurance policies are the responsibility of the client. Additional fees will be assessed if a letter or copy of your chart is requested, at the rate of **$125.00 per hour**.

In the event an appointment cannot be kept, I require 24 hours cancellation notice. A $50.00 fee will be assessed to you for failure to provide at least 24 hours notice of breaking an appointment. Insurance companies do not reimburse for appointments not kept. This fee is due prior to another appointment being scheduled following a missed appointment.

I authorize treatment and the release of information needed to process my insurance claim and request payment of benefits to **Deborah Baldwin, MS LPCC LCC**. If this treatment is for a minor child, I am the parent or legal guardian who is legally permitted to authorize treatment for this child.

I have been given a copy of **Patients' Rights**.

An important patient right is Confidentiality. Information obtained during the course of assessment and therapy is maintained in strict confidence, in accordance with state law. Records may be released only with the written permission of the client, or legal guardian of the client. The only exceptions are in the case of intent to harm self or others, suspected child abuse, under court order, or when the client shares information in the presence of others. There are also limits to children's confidentiality.

I am available during regular business hours. **In the event of a life threatening emergency, please go to your nearest emergency room or call 911**. Once the immediate emergency is addressed, you may call the emergency number included on my answering machine.

I have read and agree to these policies:

Signature **Date**