Sheryl R. Jacobs, Ph.D., P.C.

8 Reservoir Circle, Suite 105
Baltimore, MD 21208

Phone: (410) 580 9045
Fax: (410) 580 9046

REGISTRATION FORM FOR ADULTS

CLIENT INFORMATION								
Name			Referred by:					
Street								
City			State		Zip			
Home Phone ( )			Cell Phone ( )					
Work Phone ( )			Email:					
Date of Birth			Gender ___ Male ___ Female					
Relationship to Policyholder	**Self**		**Spouse**		**Child**		**Other**	
Employment Status	**Full Time**		**Part Time**		**Unemployed**			
School Status	**Full Time**		**Part Time**		**Does not attend school**			
Is treatment related to	**Employment**		**Auto Accident**		**Other Accident**		**N/A**	

Dr. Jacobs does not participate with any insurance plans, and her practice is a "fee for service" practice. Although full payment is expected at the time of the visit, Dr. Jacobs can file a claim for the services provided to you. However, if additional phone calls are required due to claim issues, the client is responsible for making any follow up calls or additional corrected claim filing. You can also be provided with a monthly statement that includes all necessary information to file a claim yourself or to use with your Health Service Account or Flex Spending Account. ONLY PROVIDE INSURANCE INFORMATION IF YOU WANT SHERYL R. JACOBS PH.D. P.C. TO FILE A CLAIM FOR YOU.

POLICYHOLDER/INSURANCE INFORMATION			
Name			Group #
Street	Member ID #.		
City	State		Zip
Phone (H) ( )	(W) ( )		Other ( )
Date of Birth	Gender (circle) M F		
Insurance Company	Phone ( )		
Street	City	State	Zip
Employer	Authorization #		

Client's Name_____Date of Birth_____

Physician_____
Phone_____
Physician's Address_____
_____

Other Family Members	Relationship	Date of Birth

Marital Status ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Single**

How long married?_____ **How long divorced?_____**

Person to contact in case of emergency:
Name:_____
Phone Number _____
Relationship_____

School level completed_____ Occupation _____

Hospitalizations_____

Allergies_____

Chronic Medical Conditions (i.e. asthma, ear infections)_____

Current Medical Concerns_____
_____

Current Medications and Dosage_____
_____

Client's Name_____**Date of Birth**_____

Please list the problems with which you want help:

1_____

2_____

3_____

4_____

Have you received any other therapy or special treatments (psychological counseling, psychiatric help, speech therapy, medications, diets, etc.)? ☐ **Yes** ☐ **No**

If so, please describe below:

Approximate Date(s)	Type of Treatment	Name/Address of Provider

Family History: ***Following is a list of problems that sometimes run in families. We are interested in whether anyone else in the family has had any problems in these areas.***

Family History	Mother	Father	Brother(s)	Sister(s)	Others (e.g. aunt)
Hyperactive as child					
Behavior Problems					
In trouble as a teen					
Trouble learning to read					
Trouble learning to write					
Trouble with math					
Kept back in school					
Drug/alcohol Problems					
Anxiety					
Depression					
Psychiatric Hospitalization					

Signature_____ *Date* _____

SUMMARY OF THERAPIST PATIENT AGREEMENT
for the office of Sheryl R. Jacobs, Ph.D. P.C.

(Initial)

_____I have been made aware that there is a Therapist Patient Agreement and Maryland Notice Form on Dr. Sheryl R. Jacobs' website (www.sherylrjacobs.com) and that I have either read this document on her website or can download a copy for my records. If I do not have internet access I have been provided with a copy of Dr. Jacobs' Therapist Patient Agreement and Maryland Notice Form, or reviewed a copy at her office.

_____Payment of fees is required at the time of the visit for out of network services.. Dr. Jacobs will be glad to complete any outpatient treatment plans necessary in order for me to receive my out of network benefits. However, I understand that if I have an HMO or Medicare, I will need to sign a Private Patient Contract with Dr. Jacobs, and will not be able to submit for reimbursement through this insurance. Dr. Jacobs can provide me with a statement with the necessary insurance information that I may use in order to be reimbursed.

_____I WOULD or WOULD NOT (circle one) like Dr. Jacobs to electronically file one claim for each date of service as indicated on my patient registration packet.

_____Dr. Jacobs requires 48 hours advance notice of cancellation or I will be billed a late cancellation/no show fee of $75 for the session.

_____I understand that I am required to obtain authorization for mental health services by contacting my PPO or POS insurance company, and I will keep Dr. Jacobs informed of any changes in my insurance plan.

_____If I am unable to reach Dr. Jacobs directly in case of emergency, I have been told to call her emergency number (cell) at 410-409 2135 or call 911 or proceed to the nearest emergency room if I cannot wait for a return call.

_____Email is not considered a secure or confidential form of communication and therefore should not be used for communication. Encrypted email may be used per the instructions made available to me by the Encrypting Email Form.

_____Email is not checked on a regular basis and therefore should not be used for emergency communications or for same day or late cancellations.

_____Text messaging is not considered a secure or confidential form of communication, and should not be used for routine or emergency communication.

_____I WOULD or WOULD NOT (circle one) like to receive email reminders about my appointments. T*hese reminders will be sent two days before the appointment, in order to allow for appropriate changes in your appointment time if necessary. The email will include the date and time of your appointment, but this message will not be encrypted. Health Care information can be lost, delayed, intercepted, delivered to the wrong email or corrupted. If you understand these risks, and would like me to send you an email reminder please initial. Also, I will use the email below if you have agreed to email reminders.*

Email _____

_____Services provided by Dr. Sheryl Jacobs are confidential with the exceptions listed in the Therapist-Patient Services Agreement and the Maryland Notice Privacy Act.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORMS DESCRIBED ABOVE.

_____

_____

Patient Signature Therapist Signature

_____

_____

Date Date