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

**8 Reservoir Circle, Suite 105**
**Baltimore, MD 21208**

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

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## 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 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* _____

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Clinical Psychologist

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## Coordination of Care With Primary Care Physician

**I, _____, hereby give my permission to have**

**Sheryl R. Jacobs, Ph.D., P.C.**
**8 Reservoir Circle, Suite 105**
**Baltimore, MD 21208**
**Phone: 410-580-9045**
**Fax: 410-580-9046**

**Release/receive information to/from:**

**Primary Care Physician** _____
**Address** _____
_____
_____
**Phone:** _____

**RE:** **Patient's Name:** _____
**Patient's Date of Birth :** _____
**Address of Patient:** _____
_____
_____

**The specific information to be disclosed includes dates of treatment, diagnosis, treatment plan, treatment progress, psychological evaluation, and any other information listed below.**

_____

**I understand that I have the right to inspect the information to be disclosed, that the refusal to consent to the release means no information will be given and this consent may be revoked at any time prior to the information being sent. This authorization is valid until**

**Date:** _____

**Signature of Patient:** _____
**Signature of Parent or Guardian:** _____
**Witness:** _____
**Date of Consent:** _____

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## Email Policy

In order to comply with HIPPA rules with regards to privacy and confidential communication, I am instituting an email policy. I will only be initiating or responding to client emails through an encrypted email server, Hushmail.

- ***When you receive an email from me, you will see the following in the text box:***

  **srj@sherylrjacobs.com has sent you a secure email using Hushmail.**

- ***You will then need to click on the secure link:***

  **To read it, please visit the following web page: https://www.hushmail.com/express/XY9CSEND**

- ***You will need to give me a password that can be used in response to the question which will be "you know the answer." When you have gone to the link above you will see:***

  **Question:** ***you know the answer***

- ***Once you type in your "Answer" word, you will be able to read the email.***

  **Answer:** ***your special word***

- ***If you want to respond to my email, hit reply and your reply will be encrypted back to me. However, the ability to reply to a message is only good for two weeks from opening the email.***

- ***If you want to initiate an encrypted email to me, you can set up a free Hushmail account (www.hushmail.com) and use that to send me an email. If you have a Hushmail account, you will not need to enter a password to open my encrypted email. Other email service providers are also available to encrypt email. Alternatively, you can send a request to me with the subject line "please send me an encrypted email" and I will send you an encrypted email that you can then send an encrypted response back to me.***

**I have read these instructions and understand that Dr. Sheryl Jacobs will only reply to emails about clients through this encrypted email account. This includes emails that come from collateral sources such as schools, other clinicians or any other source about me (or my child). I have also been advised that should I choose to use email to communicate with Sheryl R. Jacobs, Ph.D. I should use an encrypted email server in order to protect my PHI, or Protected Health Information.**

**Signature _____** **Witness_____**

**Date_____** **Date_____**

**Answer _____**

**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.
*These 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 and my name, 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. For example, confidentiality may be broken in instances such as suspected child abuse, or if a client is posing a risk to themselves or others.

**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