

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 CLIENTS UNDER 18

CLIENT INFORMATION									
Name				Referred by					
Street									
City				State			Zip		
Phone (H)				Cell					
Date of Birth				Gender			M F		
Marital Status		Single		Married		Divorced		Other	
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	
<p>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.</p>									
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 #					

Child's Name _____ **Date of Birth** _____
Home Address _____
School _____ **Phone** _____
Grade _____ **Teacher** _____
School Address _____
Pediatrician _____ **Phone** _____
Pediatrician's Address _____
Mother/Parent A's Name _____ **Date of Birth** _____
Parent's Address _____
Parent's Home Phone _____ **Work** _____
Cell Phone _____ **Email** _____
School level completed _____ **Occupation** _____
Father/Parent B's Name _____ **Date of Birth** _____
Parent's Address _____
Parent's Home Phone _____ **Work Phone** _____
Cell Phone _____ **Email Address** _____
School level completed _____ **Occupation** _____

Other Family Members	Relationship	Date of Birth

Status of Parent's Marriage:

☐ Married
 ☐ Separated
 ☐ Divorced
 ☐ Widowed
 ☐ Single

How long married? _____ How long divorced? _____ Child's age at divorce _____

If parents are divorced, separated, or single who has legal custody of the child?

☐ Mother/Parent A
 ☐ Father/Parent B
 ☐ Mother/Parent A and Father/Parent B
 ☐ Other _____

Child's Name _____

Please list the problems with which you want help for this child:

1. _____
2. _____
3. _____
4. _____

What have you said to the child about this evaluation? _____

Whose idea was it that this child have an evaluation? _____

Has this child received any *evaluations* or any *treatment* prior to this contact such as psychological testing, counseling, psychiatric help, speech therapy, medications, diets, etc.? ☐ Yes ☐ No

If so, please describe below:

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

Medical Issues

Hospitalizations _____

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

Allergies _____

Current Medical Concerns _____

Medication Currently Being Taken by Child: _____

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/ Parent A	Father/ Parent B	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					

Child's Name _____

BIRTH AND DEVELOPMENTAL HISTORY

Pregnancy

Length in months _____

Any illness or complications during pregnancy? ☐ Yes ☐ No

If yes, please explain _____

Medications taken by the mother during pregnancy _____

Substances used during pregnancy? ☐ Yes ☐ No

☐ Cigarettes How many? _____

☐ Alcohol How many drinks? _____

☐ Drugs Please describe types of drug use and frequency _____

Was the father using any substances during the time of conception? ☐ Yes ☐ No

If yes, please describe _____

Labor and Delivery

Was the birth of the child "normal"? _____

Did mother or baby stay in Special or Intensive Care? ☐ Yes ☐ No If yes, please explain _____

Early Development

Please describe the child as an infant (temperament, sleeping, eating patterns, etc.). _____

Ages at Milestones

Gross motor:

Crawled _____

Walked alone _____

Sat by self _____

Ran well _____

Fine motor:

Fed self with spoon _____

Scribbled _____

Tied shoes _____

Language development:

Single words _____

Used sentences _____

(2+ words) _____

Spoke clearly _____

Potty trained:

Urine for day _____

Urine for night _____

Bowels for day _____

Bowels for night _____

Rate of development overall: ☐ Slow ☐ Normal ☐ Fast

Educational History

Has this child been retained in a grade? ☐ Yes ☐ No If so, what grade? _____

Does this child receive any special education services? ☐ Yes ☐ No

If so, what types of services, and at what grade? _____

Personality and Behavior: please circle all traits that apply to the child now:

Sad	Happy	Leader	Follower	Moody	Friendly
Quiet	Overactive	Independent	Dependent	Sensitive	Affectionate
Fearful	Cooperative	Tantrums	Lethargic	Sleep Problems	Oppositional
Even Tempered	Loner	Social	Anxious	Compulsive	Forgetful

Please describe this child's strengths and interests _____

Signature of Person Completing Form _____

Relationship to child _____ Date _____

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

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.
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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:*

sri@sherylriacobs.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.sheryljacobs.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