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

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__________

Insurance I.D. :____

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>**

____

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____

What brings you in for treatment at this time?

____

____

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__________________

I authorize payment of medical benefits to Dr. Bauman for services provided.
If a problem occurs with the insurance company regarding payment of medical benefits, the patient is responsible for payment. All follow-up with the insurer is the responsibility of the insured. Signature___________________________ Date_____________________

Charges for services are due and payable at the time services are rendered. If you have health insurance, it should be understood that this is an agreement between you and your carrier. You remain directly responsible to the doctor 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.
I hereby give my consent to release necessary information for taking such action. I understand that I will be responsible for any expenses incurred due to collection or judicial actions in this regard.
Signature______________________________ Date________________________

PLEASE BE SURE TO READ YOUR COPY OF PATIENT'S RIGHTS AND RESPONSIBILITIES! Please take it with you for your records.
I have read and understand the Patient's Rights and Responsibilities. I received a copy for my records.
Signature______________________________ Date______________________________
Witness_______________________________ Date______________________________

<u>Please complete the following information as best you can. This allows for more efficient and effective use of your first session.</u>

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

Additional symptoms that are not mentioned____

MEDICAL HISTORY (List all medical problems)

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____

____

ALLERGIES:____

MENTAL HEALTH HISTORY (Include dates/providers of any hospitalizations and outpatient treatment)____

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FAMILY MENTAL HEALTH HISTORY (Please list all blood relatives who have a documented or suspected psychiatric problem, including addictive disorders)____

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Has anyone in your family tried or successfully suicided? If so, who and when?

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Have you ever tried to take your life? If so, how and when?

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