801 Northpoint Parkway, Suite 21
West Palm Beach, FL 33407
Phone: (561) 254-6589
Fax: (561) 379-1814
www.baummierhealth.com

CLIENT REGISTRATION

CLIENT NAME ____
LAST FIRST MIDDLE

ADDRESS ____

CITY ______________________________ STATE __________ ZIP ______________

HOME PHONE __________________________ CELL PHONE __________________________

SEX __________ DATE OF BIRTH ______________ AGE ________

INSURANCE POLICY HOLDER NAME ______________________________ DOB ___________

INSURNACE POLICY NUMBER ________________________ GROUP NUMBER______________

EMERGENCY CONTACT NAME ___________________________ RELATIONSHIP ___________

PHONE NUMBER ______________________

Best Phone Number to Receive Text Reminders ______________________

Name of Contact (If client is a minor) ______________________________

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all my insurance submissions
2. I authorize the release of information to my insurance company
3. I understand that I am responsible for the full amount of my bill for services provided
4. I authorize direct payment to my service provider
5. I hereby permit a copy of this to be used in place of an original

   It is your responsibility to pay any deductible amount, copay, co-insurance amount or any other balance not paid by your insurance at the date and time services are provided. If your account goes into collection, there will be a 20% fee added to your balance ______________ Initials

CONSENT TO TREATMENT

I hereby authorize Baummier Health, to administer mental health/psychiatric treatment. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that Baummier Health may be obligated to release information to my insurance company from my medical records as determined and required by my company's' guidelines and hereby authorize the release of such information. I authorize the release of pertinent information for collection purposes should it be necessary. I hereby

consent to receive consumer survey material following completion of treatment for the purposes of evaluating my satisfaction with the effectiveness of services rendered by Baummier Health ____________________ Initials

For minors: I represent and warrant that all information submitted is true and correct and that I have complete and proper authority to involve the above referenced minor client for treatment at Baummier Health. I understand that Baummier Health is relying upon my representation to accept the minor child as a client and I shall hold harmless and indemnify Baummier Health. as the result of any representations which are not true and correct. ____________________ Initials

POLICIES AND PROCEDURES

Baummier Health maintains the highest of professional and ethical standards. To serve our clients to the best of our ability, we request that you review the following policies and procedures prior to your initial session. Should you have any questions or concerns prior to signing acknowledgment of these terms, please discuss these issues with your therapist or the office manager.

Emergency Services: Baummier Health **does not** provide 24-hour emergency coverage. Should you have a potentially suicidal/homicidal situation, please **call 911 IMMEDIATELY** or go directly to the emergency room of the nearest hospital based on the severity of the situation. You may also contact the **Mobile Crisis Team** 24 hours a day / 7 day a week if you are experiencing a clinical emergency at **561-383-5777** _____________________ Initials

Confidentiality of Relationship: All information given by you or your family is treated as confidential and may be released only upon your written consent or as required by law. The legal limitations to confidentiality include: Suspected or reported child abuse/neglect, suspected or reported situations in which your therapist believes to be potentially life threatening to yourself or others, or should a court order require your therapist to provide information to the courts. _____________________ Initials

Cancelled / Missed Appointments: Appointments must be cancelled within 24 hours of your scheduled appointment. We reserve the right to charge a fee for failed appointments. Your insurance company will not pay for missed or failed appointments; therefore, you will be responsible for this fee. _____________________ Initials

Phone Contacts: Your therapist will make every effort to be available for a brief phone contact. Lengthy telephone calls, consultations and correspondence will be billed at therapy rate of $100 per hour. Should you wish to have a phone session please consult with your individual therapist. Insurance companies do not cover phone sessions. _____________________Initials

Court Testimony: We do not believe that it is advantageous to expect your therapist to testify in court. The only exception to this is if you are here originally for an evaluation regarding a legal issue. All forensic work, (e.g. depositions, testimony, court reports, research, correspondence, etc), will be billed at the rate of $250 per hour _____________________ Initials

Sessions: **Please respect that your sessions are scheduled for 45-50 minutes.** Most insurance companies pay for a 45-minute session unless otherwise noted in your original paperwork. We ask that you arrive for your session on time. Your session will be limited to the original scheduled time. Should your therapist be responsible for the session starting late, you will receive your entitled session time. ____________________ Initials

Co-Pays and Deductibles: Our office is unique in that there is no support staff on sight and all monies are collected over the phone by submitting a credit card to be kept on file. Cash is also accepted. Co-pays, deductibles, late fees are due prior to appointment to avoid rescheduling.

_______________________Initials

Insurance Premiums: From time to time we receive notification that a policy has lapsed or is in a "grace period" due to non-payment of the premium. Please be advised that when we receive such a notification we will suspend your appointments until the insurance company confirms the policy is back in effect. Or you will have the option of paying the full rate for the session

_______________________Initials

TEXT AND EMAIL CORRESPONDENCE

I acknowledge the use of text and email correspondence to and from the office of Baummier Health and release any liability to Baummier Health should any confidential information be transmitted. ______________________ Initials

INSURANCE WAIVER

All services that we provide to you in our office will be billed to your insurance company. Any services not paid by your insurance company will be your responsibility. Due to the magnitude of changes within the insurance companies, we are unable to pre-verify benefits for all insurances, as many companies subcontract their outpatient mental health benefits. Clients need to be aware of their own insurance benefits and what will be covered by their plans. It is your responsibility to obtain prior authorization if it is required by your insurance company. In addition, it is the clients' responsibility to be sure that your provider is participating with the insurance plan.

______________________ Initials

HIPAA SIGNATURE

I **acknowledge receipt of / decline a copy (circle one**) of HIPAA notice of Privacy Practices and the Office Policies and General information agreement for psychotherapy services. This signature page will be placed in your medical chart. Should you have any questions please address them with our office staff or your individual therapist.

______________________Initials

I hereby acknowledge that by signing below I accept and understand the above Office Billing and Insurance Policy, Consent for Treatment, Policies and Procedures, Insurance Waiver, and HIPAA Signature.

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Signature of Client Date

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Name of Client (Print)

____

Witness / Therapist Signature Date