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**	☐

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 #		

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:		***Fine motor***:		***Language development***:	
Crawled	_____	Fed self with spoon	_____	Single words	_____
Walked alone	_____	Scribbled	_____	Used sentences	_____
Sat by self	_____	Tied shoes	_____	(2+ words)	_____
Ran well	_____			Spoke clearly	_____

Potty trained: Urine for day_____ Bowels for day_____
Urine for night_____ 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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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:***

  Sheryl Jacobs (srj@sherylrjacobs.com) has sent you a protected message

- ***You will then need to click on the blue box that says "Read this message"***
- ***Then click on the blue box that says "Sign in with a one- time passcode"***
- ***You will be sent a temporary passcode to your email.***
- ***Once you type in your temporary passcode, the email will open.***
- ***The passcode is only good for 15 minutes, but you can request another passcode at any time, up to 90 days.***
- ***If you want to respond to my email, open the email and hit reply and your reply will be encrypted back to me.***
- ***Any attachments sent will also be encrypted when they are sent.***
- ***If you want to initiate an encrypted email to me, you can open a previous encrypted email, and use that to send your 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 containing clinical information 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. I understand that information that is put into an email and not encrypted does not protect my confidentiality.

Signature _____ Witness_____

Date_____ 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 $125 for the session. Exceptions will be made due only to emergencies, illness or inclement weather on a case by case basis.

_____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. I understand that if I do not use an encrypted email, Dr. Jacobs cannot ensure my confidentiality.

_____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 understand that if I use texting, Dr. Jacobs cannot ensure my confidentiality

_____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 and is available on her website. 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