

# 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

<i><b>CLIENT INFORMATION</b></i>									
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><b>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.</b></p>									
<i><b>POLICYHOLDER/INSURANCE INFORMATION</b></i>									
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.

<i>Family History</i>	<b>Mother/ Parent A</b>	<b>Father/ Parent B</b>	<b>Brother(s)</b>	<b>Sister(s)</b>	<b>Others (e.g. aunt)</b>
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					

**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 \_\_\_\_\_

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Clinical Psychologist

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## Coordination of Care With Primary Care Physician

I, \_\_\_\_\_, hereby give my permission to have

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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:***

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

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

To read a sample , please visit the following web page:  
<https://www.hushmail.com/express/XY9CSEND>

- ***You will then be asked to provide a unique password/passphrase that only you will know.***
- ***Once you type in your "Password/Passphrase", you will be able to read the email.***

**PLEASE KEEP THIS PASSWORD/PASSPHRASE AVAILABLE FOR FURTHER USE AS FUTURE EMAILS WILL ALSO BE SENT THROUGH ENCRYPTED EMAIL.**

- ***If you want to respond to my email, open the email and hit reply and your reply will be encrypted back to me.***
- ***The ability to reply to a specific message is only good for two weeks from opening the email, so please copy any needed information onto your desktop or print off a hard copy.***
- ***If you want to initiate an encrypted email to me, you can set up a free Hushmail account ([www.hushmail.com](http://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. 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.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. 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