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					
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 an electronic 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 AN ELECTRONIC CLAIM FOR YOU.

POLICYHOLDER/INSURANCE INFORMATION			
Name			Group #
Street	Member ID #.		
City	State		Zip
Phone (H)	(W)		Other
Date of Birth	Gender		
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_____

Parent A's Name_____ Date of Birth_____

Parent's Address_____

Parent's Home Phone_____ Work_____

Cell Phone_____ Email_____

School level completed_____ Occupation_____

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**

Parental Status:

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Other

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? (Please provide documentation)

☐ Parent A ☐ Parent B ☐ Parent A and 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. I am interested in whether anyone else in the family has had any problems in these areas.

Family History	**Parent A**	**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**_____

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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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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 secure emails through outlook except in cases of routine matters, such as scheduling appointments.

- **When you receive an email from me you will receive a secure email through my srj@sherylrjacobs.com Office 365 account.**
- **You will then need to click on the blue box that says "READ THE MESSAGE" and follow the directions for your computer.**
- **If you want to respond to my email, hit reply to the opened email and your reply will be encrypted back to me.**
- **If you want to initiate an encrypted email to me, you can ask me to send you a secure email by emailing me at srj@sherylrjacobs.com, without sending me any clinical information. I will then send you a secure email.**
- **Other email options also exist for encrypted email, but please let me know if you are sending me information through that system prior to sending me an email so that I know it is a legitimate email.**

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 and a No Surprise Act/Good Faith Estimate Notice on Dr. Sheryl R. Jacobs' website (www.sherylrjacobs.com) and that I have either read these documents on her website or can download a copy for my records. If I do not have internet access, I can request a copy of these forms or review a copy at her office.

_____Payment of fees is required at the time of the visit for all services.

_____I WOULD or ___WOULD NOT like Dr. Jacobs to electronically file one insurance claim for each date of service as indicated on my patient registration packet.

_____I will be filing on my own for my insurance reimbursement and will be given a statement by Dr. Jacobs in order to file. There are certain insurances where the client must file for reimbursement (e.g. Johns Hopkins Health Care Plans) in order to directly receive reimbursement and this will be discussed at our first meeting.

_____ 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 only due to emergencies or inclement weather.

_____I understand that I am required to obtain any authorization for mental health services by contacting my PPO or POS insurance company. 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. I will keep Dr. Jacobs informed of any changes in my insurance plan.

_____In an emergency situation when I have first tried Dr. Jacobs on her client number (410 580 9045) and I cannot wait for a return call, I will call 911 or proceed to the nearest emergency room.

_____Email is not considered a secure or confidential form of communication. A secure email may be used by requesting Dr. Jacobs to send a secure email to me through her Outlook email (srj@sherylrjacobs.com) and I can use that email to respond in a secure fashion. 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. Dr. Jacobs does not have alerts enabled to be notified that an email is sent.

_____Text messaging through 410 580 9045 although encrypted, is not necessarily secure and should not be used for emergencies or clinical information. This text system does not have a sound notification activated, and therefore may not be responded to immediately. Texts should only be used if needed for routine scheduling matters.

_____I WOULD or __WOULD NOT 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 NOTICE FORMS DESCRIBED ABOVE.

Client/Guardian _____ Therapist_____

_____ _____

Date Date