RICHARD L. BAUM, Ed.D. **ASSOCIATES IN BEHAVIORAL CARE**

PATIENT NAME____________________ DATE OF 1ST APPT.__________ PRESENTING PROBLEM____________________

HOME PHONE ( )__________ **WORK ( )**__________ **CELL**__________ **SEX: M F** **MARITAL STATUS: S M SEP D W**

ADDRESS______________________________ **CITY**______________ **STATE**__________ **ZIP**________

DOB______________ **SS#**____________________ **EMPLOYER**____________________

EMPLOYER ADDRESS____

REFERRED BY____________________ **PRIMARY CARE DR.**____________________ **PH.#**__________

EMERGENCY CONTACT RELATIONSHIP TO PT______________ **PHONE #**______________

PERSON RESPONSIBLE FOR BILL____________________ **ADDRESS IF DIFFERENT THAN PATIENT**____________________

PRIMARY INSUR. CO.____________________ **CLAIMS PH#**__________ **PH.# FOR MH BENEFITS**__________

INSURANCE CO. ADDRESS______________________________ **PRECERT PH#**__________

NAME OF POLICYHOLDER____________________ **SS#**____________________ **DOB**__________

POLICY ID #____________________ **GROUP/PLAN #**__________ **EFFECTIVE DATE**______________

POLICY HOLDER EMPLOYER____________________ **PHONE ( )**______________

SECONDARY NSUR. CO.____________________ **CLAIMS PH#**__________ **PH.# FOR MH BENEFITS**__________

INSURANCE CO. ADDRESS______________________________ **PRECERT PH#**__________

NAME OF POLICY HOLDER____________________ **SS#**____________________ **DOB**__________

POLICY ID #____________________ **GROUP/PLAN #**__________ **EFFECTIVE DATE**______________

POLICY HOLDER EMPLOYER____________________ **PHONE ( )**__________

AUTHORIZATION TO RELEASE INFORMATION, AUTHORIZATION TO DIRECT PAYMENT OR BENEFITS, AND AUTHORIZATION TO RENDER TREATMENT:
I HEREBY AUTHORIZE RICHARD L. BAUM, ED.D.

1) TO RENDER TREATMENT AND/OR SERVICES TO ME (OR MY DEPENDENT);
2) TO RELEASE ANY MEDICAL INFORMATION ACQUIRED IN THE COURSE OF EXAMINATION OR TREATMENT FOR INSURANCE PURPOSES;
3) TO USE A PHOTOCOPY OF MY SIGNATURE FOR SOLE PURPOSE OF RELEASING MEDICAL INFORMATION TO FILE HEALTH INSURANCE CLAIM FORMS ON THE PATIENT'S BEHALF;
4) TO FILE A CLAIM WITH MY INSURER FOR BENEFITS DUE ME (OR MY DEPENDENT).
5) TO COMMUNICATE WITH MY PRIMARY CARE PHYSICIAN.

I FURTHER AUTHORIZE MY INSURER TO PAY BENEFITS DUE ME DIRECTLY TO RICHARD L. BAUM, ED.D. I UNDERSTAND, IF THE DOCTOR HAS AN AGREEMENT WITH MY INSURANCE CARRIER THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF FEES IN ALIGNMENT WITH THAT AGREEEMENT OTHERWISE I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED REGARDLESS OF ANY INSURANCE COVERAGE. I ALSO UNDERSTAND THAT IF I NEED TO CANCEL AN APPOINTMENT THAT I MUST DO SO 24 HOURS OR MORE BEFORE THE APPOINTMENT OR I MAY BE CHARGED. THIS OFFICE IS HIPAA COMPLIANT.

SIGNATURE______________________________ **DATE**______________

BELOW-OFFICE USE ONLY

INSURANCE BENEFITS INFORMATION

PRIMARY	SECONDARY
CONTACT PERSON__________	CONTACT PERSON__________
EFFECTIVE DATE__________	EFFECTIVE DATE__________
DEDUCTIBLE__________	DEDUCTIBLE__________
CO-PAY__________	CO-PAY__________
MAX # SESSIONS OR $ AMOUNT__________	MAX # SESSIONS OR $ AMOUNT__________
AUTHORIZATION #__________	AUTHORIZATION #__________
RESPONSIBLE PARTY FOR PRECERT__________	RESPONSIBLE PARTY FOR PRECERT__________
ANY SESSIONS USED THIS YEAR__________	ANY SESSIONS USED THIS YEAR__________
MAIL CLAIMS TO:__________	MAIL CLAIMS TO:__________
__________	__________