DATE:_____

DIAGNOSIS (for insurance submission): _____

Caroline R. Baltzer, Ph.D.
Licensed Clinical Psychologist
158 Mt. Auburn Street
Cambridge, MA 02138
Tel: 617-438-7501

PATIENT DETAILS

TITLE: DR. MR. MRS. MS. MISS.

LAST NAME:_____FIRST NAME:_____INITIAL:_____

PHONE:_____EMAIL:_____

ADDRESS:_____CITY:_____

STATE:_____ZIP:_____

D.O.B:_____AGE:_____ SEX: MALE / FEMALE

EMERGENCY CONTACT PERSON(S): _____PHONE #_____

THEIR RELATIONSHIP TO YOU:_____

CURRENT MARITAL STATUS:_____

EMPLOYER/SCHOOL:_____

OCCUPATION:_____WORK PHONE:_____

GUARANTOR/PARENT:_____PHONE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

[FOR FILE: PRIMARY INSURANCE COVERAGE]

POLICY HOLDER:_____RELATION TO PATIENT:_____

INSURANCE CO:_____PHONE:_____

ADDRESS:_____CITY:_____ST:_____ZIP:_____

POLICY/ID#"_____GROUP#:_____PCP REFERRAL#:_____

[FOR FILE: SECONDARY INSURANCE INFORMATION]

POLICY HOLDER:_____RELATION TO PATIENT:_____

INSURANCE CO:_____PHONE:_____

ADDRESS:_____CITY:_____ST:_____ZIP:_____

POLICY/ID#"_____GROUP#:_____

REFERRING PERSON / INSTITUTION: _____

CURRENT MEMBERS OF YOUR HOUSEHOLD

NAME	AGE	RELATIONSHIP

PREVIOUS PSYCHOTHERAPY OR COUNSELING:

THERAPIST/ORGANIZATION	ADDRESS	APPROX DATES OF SERVICE

ANY PREVIOUS HOSPITALIZATIONS OF ANY KIND:

HOSPITAL	ADDRESS	APPROX DATES OF STAY

CURRENT FAMILY PRACTITIONER/INTERNIST/PCP: _____

PSYCHOPHARMACOLOGIST: _____

ANY MEDICAL PROBLEMS:_____

_____

_____

_____

_____

CURRENT MEDICATIONS & DOSES:_____

_____

_____

_____

_____

ALLERGIES:_____

_____

PLEASE READ CAREFULLY & SIGN BELOW

I AGREE TO BE TREATED IN A PSYCHOTHERAPY BY CAROLINE BALTZER, PH.D. WHO IS A LICENSED CLINICAL PSYCHOLOGIST.

THE FEE IS DUE AT THE APPOINTMENT TIME AND IS BASED ON THE FEE STRUCTURE POSTED ON DR. BALTZER'S WEBSITE.

A CANCELLED OR MISSED APPOINTMENT, WITHOUT 48 HOURS NOTICE, WILL BE BILLED AT THE CURRENT SESSION RATE DIRECTLY TO ME.

NOT ALL CLINICAL SERVICES ARE REIMBURSEABLE BY ALL INSURANCE COMPANIES. IT IS THE PATIENT'S RESPONSIBILITY TO DETERMINE THEIR COVERAGE AND BENEFITS IF THEY ARE USING HEALTH INSURANCE.

I FULLY UNDERSTAND THAT HEALTH ISURANCE POLICIES ARE AGREEMENTS BETWEEN INSURANCE CARRIER(S) AND MYSELF. FURTHERMORE, I UNDERSTAND THAT CAROLINE BALTZER Ph.D. WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN GETTING REIMBURSED BY MY INSURANCE COMPANY. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME BY CAROLINE BALTZER Ph.D. ARE MY PERSONAL RESPONSIBILITY FOR PAYMENT. I ALSO UNDERSTAND THAT UPON TERMINATION OF TREATMENT ANY MEDICAL BILLS REMAINING UNPAID BY INSURANCE ARE DUE WITHIN 30 DAYS BY ME.

I AUTHORIZE DR. BALTZER TO RELEASE ANY RELEVANT CLINICAL INFORMATION NECESSARY TO FACILITATE ANY INSURANCE CLAIMS MADE BY ME. I UNDERSTAND THAT MY TREATMENT IS NOT FULLY CONFIDENTIAL IF I AM USING MY HEALTH INSURANCE BENEFITS.

I UNDERSTAND THAT IN THE EVENT I HAVE NOT PAID ANY REMAINING BALANCE, MY ACCOUNT INFORMATION WILL BE GIVEN TO A COLLECTION AGENCY.

WHILE TREATMENT WITH DR. BALTZER IS STRICTLY CONFIDENTIAL, I AM AWARE OF THE SPECIFIC LEGAL LIMITS OF CONFIDENTIALITY.

I HAVE READ AND AGREED TO ALL THE CONDITIONS IN THIS DOCUMENT AND ATTEST TO THE ACCURACY OF ALL THE INFORMATION GIVEN HERE. I KNOW THAT I CAN REFERENCE DR. BALTZER'S WEBSITE OR ASK HER DIRECTLY FOR MORE INFORMATION PERTAINING TO TREATMENT.

_____ _____

SIGNATURE DATE