Mario Lehenbauer-Baum, PhD, Licensed Psychologist
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CLIENT INTAKE FORM

Any information provided on this form is protected as confidential information and will be part of your Clinical Record. *HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Our office will use your e-mail/mail address/phone numbers* ***ONLY*** *for general and billing inquiries, or scheduling appointments. Please check all that applies on this form:*

Contact and Insurance Information

Please note that uses and disclosures may be permitted without prior consent in an emergency!

Name:____ **DOB:** ______________ **Today's date**: _____________________

Referred By/How did you find our office? ____

Age: _______ **Gender**: ___________ **Parent/Legal Guardian** (if under 18): ____

Employment Status and Employer (or school): ____

Home Address: ____

Can we use your home address to send bills/invoices:

□ YES □ NO (*If no, please indicate another address for bills) your bills:* ____

I wish to be contacted in the following manner (please check all that applies):

□ **Home Telephone**: _____________________________
□ OK to leave message with detailed information
□ Leave message with call back number only
□ OK to talk to someone else if someone else answers the phone, such as: ______________________________

□ **Work Telephone**: _____________________________
□ OK to leave message with detailed information
□ Leave message with call back number only
□ OK to talk to someone else if someone else answers the phone, such as: ______________________________

□ **Cell Phone Number**: ____________________________
□ OK to leave message with detailed information
□ Leave message with call back number only
□ OK to talk to someone else if someone else answers the phone, such as: _____________________________

□ **Home Written Communication**
□ OK to mail to my home address stated above with Dr. Mario Lehenbauer-Baum in the return address
□ OK to mail to my home address with return address only, no name

□ **Work Written Communication**
□ OK to mail to my work address with Mario Baum's address in the return address
□ OK to mail to my work address with return address only, no name

□ **Email Address**:_________________________________
□ OK to email bills/invoices to my email address
□ OK to use this email for scheduling/re-scheduling purposes

If health insurance is used: Insurance Provider:___________________ **Insured's ID number**: ________________________

Insured's name and address (only if different from client):____

Insured's date of birth: __________ **Insured's gender**: _____________ **Relationship to Insured Person**: _______________

In case we need to reach out to an emergency contact, please list the name(s) and phone number(s):

Emergency contact name + address: ____

Emergency contact phone: ______________________ **Relationship to client:** ______________________

Can we use the emergency contact phone to talk to the emergency contact? □ YES □ NO
Can we use the emergency contact phone to leave a message with detailed information? □ YES □ NO

Name of Primary Care Physician (PCP), if any: ______________________________________
Dr. Mario Baum can ***NOT*** *automatically share treatment and assessment information with anyone else. If you want to share treatment/assessment information with other providers, please discuss it with Dr. Mario Baum in the intake session!*

Phone number of Primary Care Physician (PCP) : ______________________________________

Your signature below indicates that you agree that our office can contact you by using the address, email address and/or phone number provided above, and contact the emergency contact provided above.

______________________	______________________	______________________
Client Signature, or parent(s) if Minor or Legal Charge	**Print Name**	**Date**

______________________________________	______________________
Signature of Witness (Mario Lehenbauer-Baum)	**Date**

General Intake Information

Have you ever received mental health services (psychotherapy, psychiatric services, etc.) before?
□ No □ Yes, previous therapist/practitioner: ______________________________________

Are you currently taking any prescription medication? □ No □ Yes, the following: ______________________
____

Have you ever been prescribed psychiatric medication? □ No □ Yes, the following: ______________________

How would you rate your current physical health? (1=poor and 10=exceptional): ______________________

Please list any physical health problems you are currently experiencing: ______________________
____

How would you rate your current sleeping habits? (1=poor and 10=exceptional): ______________________

How many times/week do you exercise? __________ **What types of exercise?** ______________________

Do you drink alcohol more than once a week? □ No □ Yes – please list how much: ______________________

How often do engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes, since (month and/or year) ______________________

How would you rate your relationship on a scale of 1-10: (1=poor and 10=exceptional): ______________________

Any there any recent life changes or stressful events? ______________________________________
____

Are you currently experiencing:

Overwhelming Sadness: □ No □ Yes, since (month and/or year) ____________________________
Grief or depression? □ No □ Yes, since (month and/or year) ____________________________
Anxiety or phobias? □ No □ Yes, since (month and/or year) ____________________________
Panics attacks? □ No □ Yes, since (month and/or year) ____________________________
Chronic pain? □ No □ Yes, since (month and/or year) ____________________________
Sleep problems? □ No □ Yes, since (month and/or year) ____________________________
Difficulties eating/eating problems: □ No □ Yes, since (month and/or year) ____________________________

Family Mental Health History

Please identify your family history of any of the following issues and the family member's relationship to you (mother, father, grandmother, uncle, etc.):

Mental health issues	Please mark	Family member(s)
Alcohol/Substance Abuse	□ No □ Yes	____
Anxiety	□ No □ Yes	____
Depression	□ No □ Yes	____
Domestic Violence	□ No □ Yes	____
Eating Disorders	□ No □ Yes	____
Obesity	□ No □ Yes	____
Obsessive Compulsive Behavior	□ No □ Yes	____
Schizophrenia	□ No □ Yes	____
Suicide Attempts	□ No □ Yes	____
Other: _____________________	□ No □ Yes	____

Do you enjoy your school/work? Is there anything stressful about school or your current work?
____

Do you consider yourself to be spiritual/religious? □ No □ Yes, please describe your faith:______________________________

What do you consider to be your three main strengths? ____

What do you consider to be your three main weaknesses? ____

What are your three major goals in coming to counseling? ____

Authorization for Use, Disclosure, Storage and Submission of Protected Health Information

When services are (partially or fully) covered by your health insurance or employee benefit plan, it requires Dr. Mario Lehenbauer-Baum to provide them with information relevant to the services that he provides to you (e.g., clinical diagnosis, Clinical Records, etc.). Psychologists are legally allowed to use or disclose your Protected Health Information (PHI) and Clinical Records or any other information for payment, treatment, and health care operations purposes when your services are covered by health insurance or other providers. Our office uses electronic software to submit claims to health insurance providers, to track claims and payments, to schedule appointments, and to record and store clinical, therapy and progress notes online. Please note that the used software (e.g., for billing, or for electronic health/clinical records) are compliant to HIPAA (Health Insurance Portability and Accountability Act of 1996). Our office uses SimplePractice; it is an online-based billing, practice and clinical records management program that also allows clients to track and cancel appointments. To set up a SimplePractice client portal account for you, please provide us with **your confidential email-address** (please use an email-address that only you have access to - do not use work/college email-addresses). You will receive a request to sign up at the portal and sign all necessary treatment consent forms. Please make sure you sign all forms within two weeks:

Email for SimplePractice client portal: ____

Also, by signing below, you understand (and agree to it) that our office has to store, maintain and submit (electronically or through other means) protected health information and/or other necessary information to health insurance and other providers (e.g., Office Ally, other billing software providers, etc.) for treatment, payment, and health care operations purposes on/for all days you receive services. With your signature below, you also agree to your protected health information and your treatment and other confidential information being stored online within the SimplePractice online practice management system.

Authorization and Signature

I authorize the release of my confidential protected health information and my Clinical/Medical Record(s) (e.g., progress notes), as described above, to be submitted and stored online and in physical locations for billing and practice management purposes, and to be used by billing agents and software, health insurance and other providers (e.g. for chart reviews). I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I understand that my protected health information needs to be re-disclosed for billing and practice management purposes every time I receive a service, and my signature indicates that I agree to my protected health information to be re-disclosed to billing software/agents, health insurance and other providers every time I receive a service. If services are covered in full or partially by health insurance providers, I also understand that health insurance providers (or agencies affiliated with health insurance providers) may ask for copies of my clinical records; my signature below indicates that I agree to Dr. Mario Baum sending copies in whatever way necessary to health insurance providers without having to contact or inform me. By signing below, I also understand and agree that Dr. Lehenbauer-Baum has to submit and store protected health information and/or other necessary information online, send it to billing agents, health insurance and other providers for payment, treatment, and health care operations purposes every time I see him. With my signature, I also indicate that I received a copy of this authorization form.

______________________	______________________	______________________
Client Signature, or parent(s) if Minor or Legal Charge	**Print Name**	**Date**

____	______________________
Signature of Witness (Mario Lehenbauer-Baum)	**Date**

Appointment, Fee and Cancellation policy

Regular professional fee and session length: The regular professional ("private-pay") fee is $ 150/individual session and $ 170/couple or family session. Psychological assessment/evaluation fees vary between $ 1200 and $ 1600 (actual fee may be higher or lower, depending on the assessments' length and purpose; please verify with Dr. Lehenbauer-Baum).

In-network services: Dr. Mario Lehenbauer-Baum is currently in-network with Aetna and BlueCross/BlueShield. The session length varies by insurance providers (45 min. for BlueCross/BlueShild; 50 to 55 min. for Aetna). You are responsible for updating any addresses, to provide information when/if you move to a different address, or when/if your health insurance coverage changes. If you change your health insurance provider, and Dr. Mario Lehenbauer-Baum is not in-network with your new insurance provider, **you are responsible for the full professional fee of $ 150/session.** Before the first session, please verify that Dr. Mario Lehenbauer-Baum is in-network with your specific plan (please call your insurance provider to make sure). If your sessions are not covered, or the coverage changed/ended in between, you are responsible for the full professional fee of $ 150/session (even if you were under the impression that sessions were covered). There is no reimbursement for psychological services that you already received and paid for.

Payments and unpaid fees: Our office accepts payments with credit/debit cards, cash and checks. When you sign up for the patient portal, it is our policy to **store your credit card information** as well; all professional fees, co-pays and/or any other payments will be collected at the end of every session (unless other arrangements have been made), or will be **automatically withdrawn from your credit card on file** within the patient portal (via Stripe, a wireless credit card payment system). If there is a negative balance on your account, and/or you forgot to pay your fees in time, Dr. Mario Lehenbauer-Baum usually tries to contact you with phone or email one or two times to provide information about fee balances, and will ask you to provide an answer how you want to pay. However, if your account has not been paid for more than 60 days, and you did not react to any of the emails or phone calls from Dr. Mario Lehenbauer-Baum, and/or other arrangements for payment have not been agreed upon, our office may use legal means to secure a payment. Legal means may involve hiring an **attorney**, a **collection agency** or going through **small claims court** which will require Dr. Mario Lehenbauer-Baum to disclose your otherwise confidential information. If such legal action is necessary, its costs will be included in the claim! **Therefore, make sure to pay for all your fees in time if you receive an email or a letter from us.**

Appointment Cancellation and No-Show Fee Policy: If you need to cancel or reschedule a session, please provide Dr. Baum with a <u>**4 hours' notice**</u>. **Please note that health insurance providers do not provide any reimbursements for missed or cancelled sessions**; if you miss a session without canceling **at least 4 hours** before, or you forget to show up, you take that time away from another client. **Therefore, the policy is to collect the regular professional fee of <u>$ 150 as no-show fee</u>** (regardless if other sessions were covered by health insurance providers!); with your signature below, you understand that our office will automatically withdraw the no-show fee of $ 150 from your credit card stored in our practice management system if you do not cancel at least 4 hours before the session starts.

Appointment, Fee and Cancellation Policy Agreement:
We appreciate your help in keeping the office schedule running timely and efficiently. By signing below, you understand the above appointment and cancellation policies and you agree to them.

______________________________	______________________________	______________________________
Client Signature, or parent(s) if Minor or Legal Charge	**Print Name**	**Date**

____	______________________________
Signature of Witness (Mario Lehenbauer-Baum)	**Date**