Michael Baron, Ph.D.
NEW CLIENT INFORMATION

If under age 18, please have adult guardian complete, with minor's input on last question on p.1.
If a couple, please complete this one form only.

Date: _____
First name: _____ middle: _____ last: _____
Address: street: _____ city: _____ state: _____ zip: _____
Sex (circle): M F date of birth: _____ age: ____ Social Security No.: _____
Home phone: _____ Cell phone: _____
Work phone: _____ Email address: _____
Occupation: _____ Employer: _____
Marital status (check): ___ never married ___ married ___ divorced
___ separated ___ widow(er)
Spouse/partner: _____ sex (circle): M F age: _____
Spouse occupation: _____ Employer: _____
In case of emergency, local person who can be contacted:
Name: _____ relationship: _____ phone: _____
Who referred you to Dr. Baron? _____
Primary Care Physician: _____ phone: _____
Current meds: _____ date of last visit to doctor: _____
Reason for last doctor visit: _____
_____
Other doctors presently seen (note specialty): _____
_____

Indicate names of your Husband (H), Wife (W), Sons (S), Daughters (D), Mother (M), Father (F), and Other household members (O) using these letter abbreviations to indicate their relationship to you and ages. If no longer living, indicate the age and year when they passed away.

_____ ( ) ____ yrs. _____ ( ) ____ yrs
_____ ( ) ____ yrs. _____ ( ) ____ yrs
_____ ( ) ____ yrs. _____ ( ) ____ yrs
_____ ( ) ____ yrs. _____ ( ) ____ yrs

Place a checkmark (√) in front of the names of all (above) who live with you.

If you were previously in therapy, who was/were your therapist(s) and approximate dates when seen:
_____
_____

Goals of therapy: What observable changes in yourself, your behavior, or your life would you most like to achieve by the end of therapy? One way of thinking about this is as follows: Imagine a non-stop movie film of your life for a typical week *before* therapy and a movie film of your life for a typical week *after* therapy. If therapy is beneficial, these movie films will look different from one another. Some desired things may be happening more often (or for the first time); some undesirable things may be happening less often (or not at all). Please list examples of those changes you are seeking:

1. _____
_____
2. _____
_____
3. _____
_____

PLEASE COMPLETE ALL PAGES

Briefly describe your problem or concern and when it began: _____
_____
_____

List any significant changes or stressors in your life in the last year: _____
_____
_____

Do you drink alcohol? ____ If yes, describe your typical amount of drinking: _____
_____

Have you ever had problems with substance abuse (including over-the-counter or prescription medications, illicit drugs, caffeine, or tobacco) or been in treatment for substance abuse? ____ If yes, please describe:
_____
_____
_____

Have you experienced any of the following as a child or an adult?

Sexual Abuse:	Yes	No	Physical Abuse:	Yes	No
Emotional Abuse:	Yes	No	Victim of Crime:	Yes	No
Eating Disorder	Yes	No	Suicide Attempt or Thoughts	Yes	No

Please list any health problems you currently have: _____
_____
_____

Please list any major health problems you have had in the past including operations, hospitalizations, and serious accidents or injuries (include approximate year): _____
_____
_____
_____

Do you have any current, past, or future legal problems or concerns? _____
_____

Do you have and financial problems or concerns? _____ If yes, please describe: _____
_____

Are you having any problems with your job or school? _____
_____

Please describe your hobbies, special interests, talents, or particular strengths: _____
_____
_____

Primary Insurance Company: _____ Copay: _____
Insured's name: _____ Policy ID: _____ Group #:_____
Relationship of client to insured: _____

Secondary Insurance Company: _____ Copay: _____
Insured's name: _____ Policy ID: _____ Group #: _____
Relationship of client to insured: _____

If insurance not used, fee to be paid at each session (see Sliding Fee Schedule on p. 3): _____
Except in the case of illness or emergencies, please note that a session cancelled without 24-hour notice may be charged a full-session fee to the client.

PLEASE COMPLETE ALL PAGES

PROFESSIONAL FEE INFORMATION

Effective November 1, 2010

SESSION FEES: Listed below are the standard fees for services by Dr. Baron. Gross receipt taxes may be added to these fees. Most sessions are 45-55 minutes in length.

Service	**Ph.D. Fees**
Initial Interview	$175.00
45-55 min. session	$150.00
Longer session	$150.00 + $50.00 per additional 15 min
Reports/testimony/travel	$200.00 per hour

SLIDING FEE SCHEDULE: Clients who do not have or choose not to use insurance can opt to use the following sliding fee schedule, based on combined annual family income, to determine the fees for services. (Where services are provided to children of divorced parents, use the combined income of both families.)

Annual Income	Fee	Annual Income	Fee
under $20,000	$50	$60-70,000	$100
$20-30,000	$60	$70-80,000	$110
$30-40,000	$70	$80-90,000	$120
$40-50,000	$80	$90-100,000	$130
$50-60,000	$90	$100-110,000	$140
		over $110,000	$150

TELEPHONE CONSULTATIONS: During regular office hours, and after hours, urgent telephone calls which last 15 minutes or longer will be billed on a prorated basis, based on the total fee Dr. Baron would normally charge for seeing you in his office. Because insurance companies will not reimburse therapists for telephone consultations, you will be responsible for these charges.

EMAIL CORRESPONDENCE: Email can be a convenient way to correspond. Presently, Dr. Baron prefers email be used for messages which relate to scheduling or rescheduling appointments or other brief matters. Given the unpredictable nature of email at times, if you have not heard back from Dr. Baron in a timely fashion, you may wish to leave a message with his answering service. For clients wishing to share extensive personal "therapy-like" information via email, please first obtain Dr. Baron's agreement to do so. You can be charged at the normal in-office rates for Dr. Baron to review and/or respond to such emails, as such charges cannot be billed to insurance.

INSURANCE: Many health insurance plans cover the outpatient services of an independently licensed mental health professional. If you have applicable coverage, check with your insurance company, your agent, or your insurance brochure to determine the extent of reimbursement. You may be required to get prior authorization from your insurance company, HMO, or Employee Assistance Program (EAP). As well, some insurance coverage requires that you *first* meet a deductible during your coverage year *before* your copay (e.g., "20%") kicks in. Best that you check with your insurance company before you arrive at your first appointment. If Dr. Baron is to file insurance for you, please make sure Dr. Baron has the insurance information he needs to file the claim. Bring your insurance card with you to the first session. There will be brief information for you to provide on a claim form when you arrive for your first session. Should difficulties with your insurance company occur, you may be requested to assist in resolving them.

PAYMENT: The preferred policy is for Dr. Baron's clients to pay for each session at the end of each office visit. You may pay by cash or check. **Checks should be made payable to Michael Baron, Ph.D.** If you are a member of certain health plans, or if you have Medicare or Medicaid, and you choose to use such, Dr. Baron is

required to file such claims. He is then reimbursed directly by the health plan. Depending on the coverage, however, you may be required to make a co-payment at the end of each session. It is possible for you to make specific arrangements with Dr, Baron for alternative payment schedules, especially if you are expecting your insurance company to pay for part of the services. **However, it is important to remember that you are ultimately responsible for payment of the services you receive.**

If you start having difficulty meeting your financial responsibilities, please discuss this with Dr. Baron. If you pay by check and it is returned, a charge of $25.00 may be assessed. Unpaid balances that are 30 or more days overdue may be subject to an interest charge of 1% per month. Unpaid balances more than 90 days overdue may be sent for collections and a collection expense may be added to your bill.

MISSED SESSIONS: If you must cancel an appointment please provide at least 24 hours notice in advance of your appointment time or by the Friday before a Monday appointment. Without such advance notice, except in the rare instances of illness or an emergency, you may be billed for that session at the regular full-session rate. Insurance companies will not cover payment for missed sessions, and it will be your responsibility for payment for missed sessions.

EMERGENCIES: If you have a medical emergency, call 911. If you have a non-medical emergency and you need to be in touch with Dr. Baron during regular office hours, please call 505-THERAPY (843-7279) and identify the situation as an emergency to the answering service. If it is an after-hours non-medical emergency, you may also call 505-THERAPY (843-7279). The psychologist on call will then be contacted and you will receive a return call. Another resource is the University of New Mexico's Mental Health Center: 505-272-2800.

If you have any questions about fees, payment plans, insurance, or other financial concerns, please consult with Dr. Baron prior to or during your first session.

This is to verify that I have ready, understand, and agree with the above.

Signature ---------- Date ----------

PLEASE COMPLETE ALL PAGES

INFORMED CONSENT

I have chosen to receive treatment by Dr. Michael Baron. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because behavioral health treatment is a cooperative effort between Dr. Baron, and me I will work with him to the best of my ability to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I have read and been given a copy (if so requested) of the basic rights of individuals who are receiving treatment by Dr. Baron. These rights include the following:

1. The right to be informed of the steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm abuse or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that Dr. Baron report all cases in which there exists a danger to self and others.

I understand that there may be other circumstances in which the law requires Dr. Baron to disclose confidential information.

I understand that Dr. Baron and my primary care physician or other healthcare provider listed below may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for coordination of treatment, case management, claims processing, quality assurance, or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the information above and I give my consent for treatment with Dr. Baron.

Signature of client ---------- Date ----------

Signature of parent, guardian, or authorized representative (when required):

---------- Date ----------

PLEASE COMPLETE ALL PAGES

RELEASE OF INFORMATION

I (print name:) _____authorize Dr. Michael Baron to contact and exchange information with the following: **(Do not leave space blank.** Please include at least the primary care physician, any provider who may be prescribing medication for purposes of mood or behavior regulation, and any referring provider with whom you may wish Dr. Baron to exchange information, if needed.)

Signature of client _____ Date _____

Signature of parent, guardian, or authorized representative (when required):

_____ Date _____

PLEASE COMPLETE ALL PAGES

Michael Baron, Ph.D.
P.O. Box 2848
696 Mission Valley Rd.
Corrales, NM 87048-2848
Phone: 505-898-4799

Acknowledgement Form

I acknowledge that I received a copy of the "Notice of Psychologists' Policies and Practices to Protect the Privacy of your health information," and that I understood it.

_____
Client's name (please print)

_____ _____
Signature of client date
(If client under 18, signature of guardian)

PLEASE COMPLETE ALL PAGES