Barney Greenspan, Ph.D.
1500 East Heritage Park Street - Suite 125
Meridian, ID 83646
208 884 1205

Client Information

Date: ______________________________

Please print
Client Name: ____
First Middle Last
Address: ____-_____
Street City State Zip
Phone (home): (______)_____-_________ Phone (work): (______)_____-_______

Phone (cell): (______)_____-_______ Referred by: ______________________________

Social Security Number: _____-____-_____ Birth Date: ________ Age: ______ Sex: M __or F __

Employer: __________________________________ Occupation: ___________________________________

Employer Address: ____
Street City State Zip

Employer Phone: (______)______-________ Reason For Visit: ______________________________

Spouse Information: Name: _____________________________________ Birth Date: _______________

Social Security Number: _____-____-______ Occupation: ___________________________________

Employer: __________________________________ Employer Phone: (______)_____-_________

Employer Address: ____
Street City State Zip

Name and address of person financially responsible, **if not** listed above:

Name: ____________________________ Birth Date: _________ Social Security Number: ___-___-____

Address: ____
Street City State Zip

Phone (home): (______)_____-________ Phone (work): (______)_____-________

Social Security Number: ______-____-______ Relationship to Client: _________________________

Insurance Assignment: I hereby authorize my insurance benefits to be paid directly to Dr. Barney Greenspan. I further authorize Dr. Barney Greenspan to release information required to process claims for his professional services.

Dr. Greenspan will request a copy of your insurance card to ensure accuracy; otherwise, fill out this indented section

Insured's Name (if different from client above): ____________________________

Name of Medical Insurance: ___________________________ Insurance Phone #: (____)_____-______

Address of Insurance: ____-_____
Street City State Zip

Group Number: ____________________________ Policy Number: _______________________________

Employer of Insured Person: ____

Name of Worker's Comp.: __________________________________ Phone Number: (____)____-_____

Claim Number: ______________________________ Adjuster's Name: ___________________________

Signature: ____ Date: _________________________

Financial Policy: You are personally responsible for your entire bill regardless of any amount that may be covered by your insurance or a third party payer. Please call your insurance company and confirm your "outpatient mental health" benefits. As a courtesy, Dr. Greenspan will submit a claim to your primary insurance company. S*econdary insurance plans will not be billed*. **If Dr. Greenspan is a "Preferred Provider" for your insurance plan, he will abide by their contracted rates.**

Your co-payment is due at the time of service. This office takes cash or checks. Credit cards are not accepted. There will be a charge of $25.00 for any returned check due to insufficient funds. If you are being seen due to a court order or other legal matter, it is not certain that insurance will cover the services. Please inform Dr. Greenspan if these circumstances pertain.

Cancellation or No Show Policy: Because your appointment time is set aside specifically for you, there may be a charge of **$80.00** for any missed appointment, except for illness, if not cancelled at least **24 hours prior** to the time of the appointment

Confidentiality: This section is condensed from the Idaho Notice Form for HIPAA. State law, and professional ethics, requires therapists to maintain confidentiality, except for the following situations:

1. If there is suspected child abuse, elder abuse and/or dependent adult abuse.
2. "Tarasoff" situations in which serious threat to a reasonably well-identified victim is communicated to the therapist.
3. When threat to injure or kill oneself is communicated to the therapist.
4. If you are required to sign a release of confidential information by your medical insurance.
5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. **Think carefully and consult with an attorney before you sign away your rights.** We can discuss some foreseeable possibilities together.

6. Clients being seen in couple or family therapy are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in the treatment process.
7. I may, at times, speak with professional colleagues about our work without asking permission, but all identities will be disguised.
8. My Executive Administrator has access to locked records, but is legally charged with confidentiality.
9. Clients under age 18 do not have full confidentiality from their parents.
10. It is also important to be aware of other potential limits to confidentiality that includes the following:
    - All records may be subject to court subpoena under certain circumstances. All records are stored in locked files.
    - Cell phones, faxes and emails are used on some occasions; any electronic communication may malfunction, thus resulting in compromised confidentiality.

As a courtesy, you may be called in advance of an appointment as a reminder. If you do not want your home or work to be contacted for confidentiality reasons, please tell Dr. Barney Greenspan or his Executive Administrator.

I have read, and understand, the above policies.

Signature: ____ **Date**: ____________________

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE

IDAHO NOTICE FORM FOR HIPAA

Signature: ____ **Date**: ____________________

<u>Clients with Medicare/Medigap Insurance only</u>

Medicare/Medigap Authorization

I request that payment of authorized Medicare and Medigap benefits be made on my behalf to Barney Greenspan, Ph.D. for any services furnished to me by that clinical psychologist. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

__________ ______________________________ ______________________________
Date **Name of Beneficiary** **Health Insurance Claim Number**

____
Medigap Policy Number

____
Signature