NAOMI JACOBS, Ph.D.

Licensed Psychologist / License # PY6330

100 Executive Way, Suite 207, Ponte Vedra Beach, FL 32082

Office # (904) 687-6336 / Fax # (904) 373-0170

CHILD- PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____ M / F _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell Phone#: _____

Patient Social Security#: _____ Primary Care Physician: _____

PARENT'S INFORMATION:

Father/ Guardian Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

(H) #: _____ (C) #: _____ (W) #: _____

(H) Email Address: _____ (W) Email Address: _____

Father Marital Status: (Please circle one) **Single** **Married** **Separated** **Divorced** **Widowed**

Mother/Guardian Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

(H) #: _____ (C) #: _____ (W) #: _____

(H) Email Address: _____ (W) Email Address: _____

Mother Marital Status: (Please circle one) **Single** **Married** **Separated** **Divorced** **Widowed**

INSURANCE INFORMATION

Primary Insurance: _____ Insurance ID#: _____ Group ID#: _____

Insured/Guardian Name: _____ Employer: _____

Insured Social Security#: _____ DOB: _____

Secondary Insurance: _____ Insurance ID#: _____ Group ID#: _____

Insured/Guardian Name: _____ Employer: _____

Insured Social Security#: _____ DOB: _____

AUTHORIZATION FOR TREATMENT

My signature below indicates that I have consented to the evaluation and treatment by:

Naomi Jacobs, Ph.D.

I certify that I understand the financial and insurance billing policies for this provider, and acknowledge that all of my questions, if any, have been answered to my satisfaction. Additionally, I authorized the release of any information necessary to process a claim on my behalf to all pertinent insurance carriers.

_____ _____

Patient Signature **Date**

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History Form

Please describe the nature of the problem or concern that brings you here.

_____

_____

_____

_____

Approximate date current problem started: _____

Have you had previous mental health treatment? _____ Yes or _____ No

If yes, please give date of first treatment _____ Date of last treatment _____

Name of previous Mental Health Care Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Office #_____ Fax#: _____

Name of Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Office #_____ Fax#: _____

Who were you referred by or how did you hear about me? _____

_____

Are you involved with any current or potential litigation at this time? _____ Yes or _____ No
If yes, Please explain:

_____

_____

_____

Agreement for Telehealth/Teletherapy with Dr. Naomi T. Jacobs, Ph.D.

I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services to me via telehealth over secure video conferencing platform.

I understand that the laws that protect privacy and the confidentiality of my medical information also apply to telehealth or teletherapy.

I understand that while telehealth or teletherapy treatment has shown effectiveness in treating a wide range of disorders, there is no guarantee of effective treatment for all patients.

I understand that potential risks involving technology exist, including but not limited to internet interruptions and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected.

I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for creating and maintaining my user name and password and not sharing these with another person. I understand that I am responsible to ensure privacy at my own location by choosing a private location so other individuals cannot hear my conversation.

I understand that my health care provider or I can discontinue the telehealth/teletherapy services if we decide this type of service does not benefit my needs.

I have read and understand the information provided above regarding telehealth or teletherapy. I have discussed it with my health care provider, and she has answered all of my questions to my satisfaction. I hereby give informed consent for the use of telehealth or teletherapy in my care.

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patient printed name date

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patient or guardian signature date

Use of Internet to Communicate with Dr. Naomi Jacobs

100 Executive Way, Suite 207, Ponte Vedra Beach, FL 32082

If you choose to communicate by e-mail or text with Dr. Naomi Jacobs, you understand that the internet is not a secure means of communication.

Please acknowledge, by signing below, that you understand the risks inherent in communication by e-mail or text.

_____

Printed Name of Patient

_____ _____

Signature of Adult Patient, Parent or Guardian Date

Late Cancel/No Show Policy for Appointments with Dr. Naomi Jacobs

100 Executive Way, Suite 207, Ponte Vedra Beach, FL 32082

Please provide at least 24 hours' notice when cancelling appointments. If you do not, you will incur a 70.00 late cancellation fee. An exception exists if the patient becomes ill. In that case, if you cancel the day of your appointment due to illness, you will not be charged.

If you simply do not show up for your appointment, you will be charged a no-show fee of 70.00.

Please acknowledge, by signing below, that you have read and agree to the terms of this policy.

_____

Printed Name of Patient

_____ _____

Signature of Adult Patient, Parent or Guardian Date

NAOMI JACOBS, Ph.D.

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

You have the right to efficient and effective care individualized to your needs. Your treatment provider will work with you to develop a treatment plan best suited to you. You and your treatment provider will use this plan to help you deal with your problems as quickly and effectively as possible.

You have the right to be treated with dignity and respect. You will be treated with respect at all times. You will report any misconduct by your treatment provider including social invitation, suggestive remarks, or unwanted touching to the appropriate state agency.

Your treatment provider will make every effort to meet with you at your scheduled appointment time. If your treatment provider is late, he or she will extend your session if possible or will make other arrangements by mutual agreement.

You have a right to privacy and confidentiality. All records and communication about you will be treated confidentially in compliance with applicable state and federal laws. These laws my obligate your treatment provider to report suspected abuse or neglect; domestic violence, and those who pose a danger to themselves or others. If you have any questions or concerns regarding your confidentiality rights, please ask to speak with our Privacy Officer /Office Manager, Barbara Liwen.

You have a right to access your protected health information. This includes the right to inspect and obtain a copy of such information and a right to an accounting of disclosures. In addition, you have the right to request amendment or correction of inaccurate or incomplete protected health information. To exercise these rights, please discuss directly with your treatment provider.

Patient Responsibilities. Scheduled appointments are commitments. You will make every effort to be on time for your appointment. If you are late for your appointment, you understand that time will be lost from your session. If you miss an appointment without 24 hrs. notice, you understand that you will be charged a missed appointment fee.

You are responsible to pay at the time the service is rendered. You understand that Naomi Jacobs, Ph.D. does not participate in any medical health insurance provider networks. It is the patient's responsibility to submit a claim should you wish to take advantage of your medical insurance mental health out-of-network benefits. For your convenience and per your request, a copy of your encounter will be given to you at the end of your treatment session. It will identify the diagnosis, type of treatment and show your payment.

Your health is your responsibility. You will contact your treatment provider for any serious situation that arises, even if after normal office hours. To reach your treatment provider for an after hours emergency, call (904) 687-6336 and follow the instructions given. You will work with your provider to achieve your treatment goals and will advise your treatment provider of changes in your condition.

Patient (Print Name)	Patient or Guardian Signature	Date