Patient_____ Age_____ Birth Date_____

Address_____ SS#_____

City_____ Zip_____ Driver's License #_____

Phone (Home)_____ Phone (Cell) _____

Employer_____ Occupation_____

Employer's Address_____ Phone_____

Single ( ) Married ( ) Name of Spouse_____

Spouse's Employer_____ Occupation_____

Employer's Address_____ Phone_____

Were you in an automobile accident? **Yes** ( ) **No** ( ) Are you claiming this as a work injury? **Yes** ( ) **No** ( )

How were you referred to this office? _____

OFFICE POLICY

CONFIDENTIALITY: All information disclosed during treatment is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Disclosure may be required in the following circumstances: where there is a reasonable suspicion of child abuse or elder physical abuse, where there is a reasonable suspicion that the patient presents a danger of violence to others or where the patient is likely to harm himself or herself unless protective measures are taken. Disclosure may also be required pursuant to legal proceedings. Threats communicated to family members that are then communicated to me may give rise to the duty to warn.

PAYMENT FOR SERVICE: You are expected to pay for services at the time they are rendered unless other arrangements have been made. In instances where extraordinary professional time is required, you may incur additional fees. Please notify the office if any problem arises during the course of your treatment regarding your ability to pay.

INSURANCE REIMBURSEMENT: Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. We will give you a receipt that you can submit to your insurance company for reimbursement. If your insurance company has forms for the doctor to complete, be certain to bring them in at your earliest convenience. Managed care insurance coverage does vary.

LIENS: You are personally responsible for all charges incurred in this office. If you, your attorney and Dr. Bock have entered into a lien, payment will be made promptly to Dr. Bock when sufficient monies are available from your attorney=s trust fund. This office will **not** reduce the amount of a lien, nor wait for health insurance companies to respond to billing.

EMERGENCY PROCEDURE: If you need to contact Dr. Bock outside office hours, please call the office and leave a message on our voice mail, he will return your call. If an emergency arises, Dr. Bock can be paged immediately.

CANCELLATION: Since the scheduling of an appointment involves the reservation of times specifically for you, a minimum twenty-four (24) hours notice is required for rescheduling or cancellation of an appointment. **We may charge you a session fee for missed appointments without such notification; this charge cannot be billed to your insurance company.**

CONSENT FOR TREATMENT: I _____ authorize and request that Dr. Bock carry out psychological examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me and be subject to my agreement. I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. I also understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I have received a copy of Dr. Bock's Privacy Practices/Office Policy and Outpatient Services Contract, and have read, understand and agree to abide by those policies.

_____ _____ _____

Date Patient Signature Patient's Representative

_____ _____

Date Witness