BRUCE TURNQUIST, PSY.D.
& ASSOCIATES

277 Peninsula Farm Road, Suite J, Arnold, Maryland 21012
Phone: (410) 975-0105 Fax: (410) 975-0108

Patient Information

First Name: ______________________________ MI: _______ Today's Date: ________________
Last Name: _____________________________________ Male: ______ Female: _____
Address: ____
City: _________________________ State: _____________ Zip Code: ____________
Date of Birth: ________________ Social Sec. Number: _________________________
Home Phone: _____________________________________ Marital Status:
Work Phone: ______________________________________ Single Married Other
Cell Phone: _______________________________________
E-mail: ____

Financially Responsible Party (if other than patient)

Name: ___________________________________ Relationship to Patient: ____________
Address: ______________________________________ Male: _______ Female: ________
City: _________________________ State: ________ Zip Code: ____________________
Date of Birth: _______________ Social Sec. Number: __________________________
Home Phone: _____________________________________
Work Phone: ______________________________________
Cell Phone: _______________________________________
E-mail: ____

Insurance Information

Primary

Primary Insurance Co.: _________________________________ Phone: ___________________
Mental Health Carrier: _________________________________ Phone: ___________________
Policy Holder's Name: _________________________________ Birth Date: ________________
Address: _________________________________ City: ______________________ Zip: _________
Policy ID#: __________________________________ Group#: _____________________________
SS#: ______________________________________ Relationship to Client: ___________________
Employer: ______________________________________ Effective Date: ____________________

Secondary

Secondary Insurance Co.: ______________________________ Phone: ___________________
Mental Health Carrier: _________________________________ Phone: ___________________
Policy Holder's Name: _________________________________ Birth Date: ________________
Address: _________________________________ City: ______________________ Zip: _________
Policy ID#: __________________________________ Group#: _____________________________
SS#: ______________________________________ Relationship to Client: ___________________
Employer: ______________________________________ Effective Date: ____________________

For Office Use Only: B.T. D.O. M.H. D.P.
DX: ____________; ______________; ______________; ________________
Default Procedure Code: 90806; 90847; 96101 M.A. Ph.D.
Special Arrangements: ____

Background Information

Names of members of household:

Name: ______________________________ Age: _____ Relationship to Client: ___________

Name: ______________________________ Age: _____ Relationship to Client: ___________

Name: ______________________________ Age: _____ Relationship to Client: ___________

Name: ______________________________ Age: _____ Relationship to Client: ___________

1) What is the reason, in brief, you are seeking counseling?

____

____

2) How long has this situation existed? ____

3) Has counseling been previously sought? Yes: _______ No: ________

Name of provider (If yes): _________________________________ Phone: ( )___________

I give my permission for Bruce Turnquist and Associates to contact previous provider

yes_____ no______

4) What is the name of the client's family physician or any other attending doctor?

Physician's Name: ____________________________ Phone: ( ) _______________

5) Is the client presently taking any medications? (If yes, list dosage and prescribing physician)

Medication: _________________________ Dosage: ___________________________

6) Medical Conditions, Allergies, etc.

____

____

7) How did you hear about this office?

May we contact them to thank them for the referral? Yes _______ No ___________

8) Church or synagogue affiliation ____

Payment Policy

The following information pertains to the policy of this office regarding payment for services:

1) Payment, in full, is due at the time services are rendered.
2) If the client is an unaccompanied minor, please prearrange for payment.
3) We are not in-plan providers with health insurance. If a client has out-of-network insurance benefits, we will submit claims to the insurance company for reimbursement to the client.
   Please Note: We are not responsible for claims payment. It is the responsibility of the client to make this office aware of any needed treatment plans or authorizations required by their insurance company.

CANCELLATION POLICY

It is requested that all cancelled appointments be given with at least 24 hour notice.
All no-shows and appointments not cancelled with 24-hour notice will be billed to the client (Note: insurance companies do not pay for missed appointments).

An open relationship between the therapist and client is essential to productive treatment. If there are any questions or concerns regarding this policy please discuss them with your therapist at the beginning of your session.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY

AND THE CANCELLATION POLICY AND AGREE TO THE TERMS.

____
Client or financially responsible party (Printed)

____
Client or financially responsible party (Signature) Date ________________

AUTHORIZATION AGREEMENT
TO RELEASE MEDICAL INFORMATION AND PAYMENTS

I authorize Bruce Turnquist Psy.D. and Associates to release information necessary to file a claim with my insurance company. I also agree that I will be responsible for all charges incurred by me or my dependents.

____
Client or financially responsible party (Signature) Date ________________

Confidentiality

The law protects the confidentiality of all communication between a licensed mental health professional and a client. This office can only release information with your written permission.

There are, however, circumstances in which a therapist is required by state law to breach confidentiality, with or without a client's permission, and report to the appropriate agency or take necessary protective action. These circumstances are:

If a client is threatening personal harm to themselves or others.

If child abuse is disclosed.

If I suspect the neglect or abuse of a minor.

If a client is involved in a lawsuit and a judge rules that my client's records are necessary to ensure the right of fair trial.

If a client is a minor and is suicidal I need to inform the parents and take necessary actions to assure the client's safety.

Clients under the age of eighteen (18) also benefit from client/therapist confidentiality. Please be aware that, although parents have a right to receive information about their child's treatment, therapy is more effective if specific content of our communication is confidential.

Under Maryland law, group therapy, family therapy and marital therapy participants are required to consent to the release of information. One marital partner may not waive privilege for the other. In the case of marital therapy, therefore, information may be released only if *both* parties waive privilege or if the release of the record is court ordered.

I HAVE READ AND UNDERSTAND THE LIMITS OF CLIENT/THERAPIST CONFIDENTIALITY AS INDICATED BY MY/OUR SIGNATURE(s)

____________________________________ ____________
Signature (Self) Date

____________________________________ ____________
Signature (Partner) Date