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New Client Information

_____/_____/_____
Name _____ Date of Birth _____ Social Security No. _____

Home Address _____ City _____ ST _____ Zip _____

Home Ph: _____, Cell Ph: _____, Work Ph: _____

May I leave messages at your: Home (Y / N) Work: (Y / N)

Emergency Contact _____ Relationship _____ Phone _____

Employer _____ Insurance Carrier _____ Insurance ID No. _____

Personal Physician _____ Phone _____

Please list any active or chronic health problems: _____

Please list all medications you are currently taking (medical and psychiatric): _____

Years of Education/Highest Degree: _____ Occupation: _____

Marital Status: _____ Partner's Name: _____

Children/step children (names, ages): _____

Referral Information:

Please let me know how you learned of my practice. (Please check all that apply.)

Health Care Provider: _____ Name: _____

Friend or acquaintance: _____ Name: _____

Client or former client: _____ Psychotherapy Resources web page _____
Health plan's web site: _____ Other: _____

Office Policies

Fees and Billing Information: Fees are based on a 45-minute consultation hour. Payment in full is due at the time of service. It is helpful if you have your payment ready prior to your appointment so as not to interfere with valuable therapy time. Additional fees are charged for extended or frequent telephone consultation, written reports, as well as travel, preparation, and involvement in legal proceedings or other non-clinical services, unless prior arrangements have been made. These fees are not reimbursable by insurance. A monthly service charge of 1.5% may be added to accounts more than 60 days past due. Clients are responsible for all costs incurred in collecting delinquent accounts.

Missed Session Policy: Clients are responsible for the full fee for missed sessions which are not cancelled with 24 hours or one business day's notice (whichever is longer). Sessions cancelled due to illness or family illness are not charged. **Please note that health plans cannot be billed for missed sessions. Charges for missed sessions are due at the time of the next visit.**

After Hours Emergencies: I can be paged through my voicemail system by following the prompts to flag your message as urgent. If there is an imminent threat to health or safety contact the nearest hospital emergency room or dial 911. You may also access the Holly Hill Hospital RESPOND program at 250-7000. **E-mail contact should not be used for any matters of an urgent nature.**

Confidentiality: My practice is compliant with HIPPA confidentiality guidelines which are described in detail in a separate document provided to you. In general, no information will be released without your specific written consent except in the following situations;

- suspicion of child abuse or neglect
- imminent threat of physical harm to self or others
- a lawful order from a judge to produce records in court
- billing information necessary to pursue collection of a delinquent account
- consultation with professional colleagues to assure coverage in my absence or to enhance treatment planning

I will be happy to respond to any questions or reactions that you have to the above policies or about charges or bills which you receive.

I HAVE READ AND UNDERSTAND THE ABOVE OFFICE POLICIES. I AGREE TO THE TERMS HEREIN. I ACCEPT PERSONAL RESPONSIBILITY FOR ALL CHARGES INCURRED. * I AUTHORIZE DR. VOSK TO RELEASE NECESSARY WRITTEN, FAXED, AND/OR VERBAL (PHONE) INFORMATION REGARDING MY TREATMENT TO MY INSURANCE COMPANY. I CERTIFY THAT THIS AUTHORIZATION IS MADE VOLUNTARILY. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. THIS CONSENT WILL EXPIRE 18 MONTHS AFTER COMPLETION OF TREATMENT.

I WOULD LIKE A COPY OF THESE OFFICE POLICIES FOR MY OWN RECORDS: Yes _____ No _____

I GRANT PERMISSION TO CONTACT THE INDIVIDUAL OR HEALTH CARE PROVIDER NAMED ABOVE TO ACKNOWLEDGE THEIR REFERRAL Yes _____ No _____

_____/_____/_____
Signature (Client or Legal Guardian) _____ Date

* Subject to lawful provisions of applicable health care plans.