Colette C. Horn, Ph.D.
Licensed Psychologist
35 Sundial Circle,
Berlin, MD 21811
410-838-5270

Client Name_____Date of Birth_____

If the client is a minor, Parent Name_____

Address_____

Phone Number (home)_____(work)_____

(Mobile)_____Email address_____

Person financially responsible for client_____

Address_____Phone No._____

Has client had prior treatment for this problem? ☐Yes ☐No; If yes, dates_____

Name of person who referred you to this office_____

My signature below indicates my consent for treatment, and for the handling of my protected health information and the business practices as outlined in the ***Privacy Notice*** and the brochure, ***About My Practice***, which were given to me today.

I accept responsibility for payment of fees at the time the service is given, and in accordance with the fee schedule in the document, ***About My Practice***, that was given to me today. If I submit claims to my insurance company for reimbursement of fees, I realize that information supporting those claims may be requested by my insurance company or the managed care company that handles my mental health benefits. If this is the case, I authorize this office to provide the requested information. I understand that only information required for reimbursement will be provided.

I understand that I will be responsible for payment for any session I cancel less than 24 hours prior to the appointment time unless it is mutually agreed that it was due to circumstances beyond my control. For any fees not paid at the time of the service, I will be responsible for a 1.5% per month late payment fee for any amounts due that are not paid within 30 days of the billing date. I will be responsible for all costs associated with collection by a third party should this become necessary.

Signature_____Date_____