Dr. Jennifer Marks-Foster

NEW PATIENT INFORMATION SHEET

LAST NAME:_____ FIRST NAME:_____ DATE OF BIRTH_____

HOME ADDRESS:_____

CITY, STATE, ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

WORK PHONE:_____ **Would you like to receive appointment reminders?**

EMAIL:_____ ⌗ YES ⌗ NO (CHOOSE ONE) ⌗TEXT ⌗ EMAIL (CHOOSE ONE)

OCCUPATIONAL / SCHOOL STATUS: _____

EMPLOYER / SCHOOL NAME:_____

REFERRAL SOURCE: _____

PARTY RESPONSIBLE FOR THE BILL: _____

RELATIONSHIP TO PATIENT: _____

PRIMARY INSURANCE:_____

MEMBER NAME:_____ MEMBER DOB (MM/DD/YY) _____

MEMBER ADDRESS

_____

MEMBER ID #:_____ GROUP # _____

COPAY OR DEDUCTIBLE AMOUNT _____

I authorize you to release information to my insurance company which may include diagnoses and other treatment information in order to obtain benefits. I authorize my insurance benefits to be paid directly to Jennifer Marks-Foster, PsyD. I understand that my insurance is being filed as a courtesy and any balance not paid by my insurance company for any reason will become my full responsibility. Co-payments must be made when you check-in for scheduled appointments. Unpaid balances are subject to a finance charge and to collections services. I agree to reimburse any collection fee charges that result from collection of a past due amount.

I authorize my email address to be used privately (blind cc) to receive updates from Jennifer Marks-Foster, PsyD about upcoming classes and programs, as well as new services offered. I can opt out of this at any time.

24 HOURS NOTICE IS REQUIRED TO CANCEL AN APPOINTMENT. IF YOU CANCEL LESS THAN 24 HOURS IN ADVANCE, FOR **ANY** REASON INCLUDING UNEXPECTED EMERGENCIES, A MISSED SESSION FEE OF $75 WILL BE CHARGED DIRECTLY TO YOU.

SIGNED (Patient or Guardian):_____

DATE: _____

801 Rue St. Francois St. Ste A. Florissant, MO. 63031 (P)314.326.7811 (F)314.329.3266

JENNIFER MARKS-FOSTER, PSYD
Policies and Procedures

I. Contact Information

801 Rue St. Francois St. Ste A
Florissant, MO. 63031
www.DrJenniferMarksPsychologist.com

Phone: 314-326-7811
Fax: 314-329-3266

In case of an emergency, please call 911 or go to the nearest emergency room.

II. Office Hours

Typical office hours for Dr. Marks-Foster are 9am to 6pm Monday-Friday, and 8:30am to 3:30pm Saturdays (twice a month).

III. Confidentiality

The privacy of your therapy is of the utmost importance to your therapist. There are times, however, when information must be shared with others. These are:

1. **Insurance** – a psychiatric diagnosis is required in order to bill your insurance.
2. **Managed Care** – All HMO's, most POS' and some PPO's require a detailed treatment plan before authorizing additional services beyond the original authorization. A typical treatment plan contains:

a. A statement of the problem for which you sought treatment
b. A psychiatric diagnosis
c. Symptoms to justify the diagnosis
d. History of alcohol or drug use
e. History of previous mental health treatment
f. Current medications
g. Treatment goals
h. The methods your therapist will use to help you achieve your goals
i. Progress made toward those goals

Your managed care plan usually requires us to keep your primary care physician informed of your treatment.

3. **Legal and Ethical Issues** – Missouri State Law requires all therapists to report any suspected cases of child abuse to the Children's Division of the Missouri Department of Social Services. Whenever a therapist has concerns that you may present a danger to yourself or others, legal and ethical standards require that steps be taken to ensure the safety of those in danger. Most of the time, this can be done within the privacy of the treatment room. However, there are occasions when your family, your doctor, hospital, the potential victim, or even the police must be notified.
4. **Case Consultation** – Without disclosing identifying information, details of your case may be brought up in consultation with other providers.

IV. Fees and Payment

A full session is 55 minutes. The fee for the **first session** (initial evaluation) is **$210,** and is **60 minutes**. Follow-up sessions are $175 each. Fees must be paid at the time of service, via cash, check or credit card. I will provide you with a receipt upon request. Shorter visits of **45 min** are

also available at a rate of **$150 per visit**. If you plan to utilize the 45 min sessions, please inform me of this during your initial visit. If you would like to **change over from 55 minute sessions, to 45 min sessions** during the course of treatment, you will begin being charged at the lower rate for the session **following** your request. This means that if you make the request to change over during a visit, the change will not take place the same day.

If you are using insurance, you are responsible for your copay or payment towards your deductible at the time of service. If your insurance requires pre-authorization, you need to supply the necessary information to me **prior to your visit, otherwise you run the risk of a denied billing claim, for which you will be responsible for paying.**

Unpaid balances over 120 days will be turned over to a collection agency. If you write a check and it is returned due to insufficient funds, you will be billed a $25 returned check charge, and I will not accept future checks.

Cancelled and Missed Sessions

Cancelled and Missed Sessions by Patient

An appointment is reserved for you. If you must cancel an appointment, **you must call the office or submit an email at least 24 hours in advance to avoid a Missed Session Fee.** The fee is **$75,** and will be billed directly to you since insurance will not cover missed sessions. Missed session fees are only avoidable by cancelling 24 hours before your visit. **No exceptions are made.** The missed session fee will be billed to your credit card on file at the time of your missed session, or is due on or before your next scheduled appointment. Six or more missed appointments in which the $75 fee is applied may result in termination of therapy. In cases of termination, referrals will be provided. **Please Note: Appointment cancelations via text message are not accepted.**

Changes in availability and cancelled appointments by the psychologist

Dr. Marks reserves the right to cancel a scheduled appointment or change her availability at any time, for any reason. Appointments which are cancelled by Dr. Marks may be done so by email or phone. If one attempt to cancel an appointment is made by Dr. Marks with no confirmation of receipt from you, then she will make a second attempt via an alternative mode of communication. For example, if Dr. Marks sends a cancellation email and receives no correspondence confirming receipt, then Dr. Marks will follow up by making a phone call. Dr. Marks will leave a voicemail message informing you of the cancellation if there is no answer to a call. If you do not wish to receive voicemails from this office, you must specify this in writing.

Recurring Appointments

Appointment times are available on a first come-first serve basis. Recurring appointment slots are available and you are encouraged to utilize them if you are confident that you will be able to attend regularly scheduled appointments. If your availability tends to change often, then you are encouraged to schedule appointments one at a time. If you choose to reserve a recurring appointment slot, **you are allotted three advance cancellations per six months or one cancellation per thirty days.** An advance cancellation is one in which you notify Dr. Marks of your cancellation 24 or more hours ahead of your appointment time.

If you have **two or more advance cancellations of recurring appointments within 30 days** of each other or **four cancellations within six months**, you will be removed from the recurring slot and required to schedule appointments one at a time. You will be able to resume recurring appointments after you have consistently attended all scheduled appointments for a span of six months. This rule does not apply to missed appointments in which the $75 fee is assessed. This rule does not apply to cancellations applied by the psychologist.

Inclement Weather Policy

V. In the event of inclement weather, an early determination as to whether the office will be closed or remain open is made. If the office will be closing, Dr. Marks will contact you. If your appointment is cancelled by Dr. Marks due to inclement weather, no fees will be applied. However, if the office remains open and do not receive notification that your appointment has been cancelled, then all missed appointment and cancellation rules and policies apply.

VI. Telephone Correspondence

Making or changing appointments, discussing bills, etc. can be handled by leaving a message on my confidential voicemail. Your call will be returned as soon as possible. Therapy on the telephone will be charged the standard fee of **$150 per 45** minutes, or a minimum of **$30 for each clinical call of less than 15 minutes.** Telephone calls cannot be billed to insurance, so you will be responsible for payments.

VII. Email Correspondence

You may contact me via email with appointment changes, referral requests, and for minor consultation between appointments. Email consultation of any kind which has not been previously discussed during a therapy session will incur a fee of $10 per email. This does not apply to appointment changes, email exchanges initiated by me, or emails in which you are only providing a therapy update and specify "DO NOT RESPOND" within the body of the message.

VIII. Text Message Correspondence

There may be times when you receive text message correspondence from me. For instance, I may send you a link to a referral or website as discussed during a therapy session. This is the extent of text message communication. If you need consultation outside of therapy, please call or email to make your request as text messages will not be utilized for this purpose.

IX. Waiting Room and Restroom Etiquette

Cleanliness

Dr. Marks would like for your time in the waiting room to be pleasant and enjoyable. For your enjoyment, there are often beverages and snacks. Please be mindful of the area and try your best to keep it clean. If you produce any trash during your time in the waiting area, please bring it into the office and place it in the trash receptacle when you enter the therapy office for your visit.

Noise/Volume

The walls of the office are thin and a sound machine is utilized in the waiting room to protect patient privacy. Please do not adjust the volume of the sound machine. While patrons of the waiting room are unable to hear what is happening inside of the therapy office, the people inside

of the office are able to hear what is happening in the waiting area. Please be respectful of patients being seen by keeping your noise level to a minimum.

Arrival and Departure Time
It is recommended that you arrive no more than ten to fifteen minutes prior to your appointment time. During this time you may enjoy refreshments. Once your appointment has ended, you are expected to clear the waiting area within ten minutes. If you are the final appointment of the day, you may be asked to clear the area within five minutes.

X. Restroom Etiquette

Dr. Marks serves both individuals and families. It is important that each person in the therapy office's privacy is maintained. Therefore, no one will be able to use the restroom except during his or her time in the therapy office. If your family member or another patient is being seen, you are expected to wait until you are called into the office for your portion of the visit before you are able to access the restroom.

If you need to use the restroom and your appointment time has not started or has already ended, you will not be permitted to do so. It is recommended that you are mindful of the time when you are being seen and allot yourself time at the beginning or end of your session to use the restroom when needed.

XI. Preparation of Written Documents

Preparation of reports, clinical summaries, and letters requested by you will require a fee based on the time spent in its preparation. The minimum fee is **$30**, which is for reports taking less than **15 minutes to prepare**. This fee will **not** be billed to insurance; therefore, **you will be responsible for payment**.

XII. Miscellaneous Charges

1. **Medical Records** – To cover time and cost to copy and mail, there is a Medical Records Handling Charge of $25 per each request to release records.
2. **Court Appearances, Depositions, and Consultations with Attorneys** – These will be charged to the patient at $200 per hour, including preparation time.

I have read and understand the above information and agree to these policies. I understand that I am responsible for all charges, regardless of insurance coverage. I agree to receive psychological services and I authorize release of information to my managed care company and/or my insurance company necessary for reimbursement.

_____ _____
Responsible Party Signature Date

_____
Client's Name (Please print)

Consent for Uses and Disclosures of Protected Health Information

This is an agreement between me, _____(CLIENT NAME), and Jennifer Marks-Foster, Psy.D.

By signing this consent form, I consent to the use and disclosure of protected health information by Jennifer Marks-Foster to carry out treatment, payment, or health care operations. Federal law requires consent prior to using or disclosing my protected health information to carry out treatment, payment, or health care operations.

This consent is voluntary. I may refuse to provide the requested consent, but I cannot be treated unless I provide the requested consent. I should refer to the Confidentiality section in the Information and Policies for a more complete description of the uses and disclosures covered by this consent.

_____I acknowledge receipt of Jennifer Marks-Foster's Information and Policies regarding Confidentiality.
(please initial)

I have the right to revoke this consent at any time by notifying Jennifer Marks-Foster. My revocation must be in writing and is effective except to the extent she has acted in reliance on my prior consent. She may decline to continue treating me if I revoke my consent.

I have the right to request that Jennifer Marks-Foster restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. She is not required to agree to a requested restriction, but, if she does agree to a requested restriction, the restriction is binding on her.

Written revocation of this consent or any other matters regarding my treatment should be directed to:

Jennifer Marks-Foster, PsyD.
801 Rue St. Francois St. Ste A
Florissant, MO. 63031

_____ _____
Signature of client or client's personal representative Date

_____ _____
Printed name of client or client's personal representative Relationship to client

Dr. Jennifer Marks-Foster

Recurring Credit Card Payment Authorization Form

Sign and complete this form to authorize Jennifer Marks-Foster, PsyD to make debits to your debit or credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a multiple transactions. If you would like to authorize a one-time debit, please specify this in the comment area below.

The following charges will be auto-withdrawn from the card listed below as as indicated in the patient policies and procedures:

1. The cost of each therapy session or the copay/deductible as specified by your insurance company.
2. Cancelled/Missed Session Fees.
3. Telephone Correspondence Fees.
4. Email Correspondence Fees
5. Written Document Fees
6. Medical Records Fees
7. Court Appearances, Depositions, and Consultations with Attorneys Fees

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Please complete the information below:

I _____ authorize Jennifer Marks-Foster, PsyD to charge my credit card
(full name)
account indicated below for the purposes listed in the previous section of this form and in the amounts listed in the policies and procedures which I have reviewed, understand, and signed. I approve charges to begin on or after on or after _____. These payments are related to my personal healthcare.
(date)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated in the signed policies and procedures only, and is valid for recurring/multiple payments. I certify that I am an authorized user of this credit/debit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to those outlined above.