Ben Rutt, Ph.D.
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Baltimore, MD 21230
(410) 995-8219

CLIENT INTAKE FORM

Date _____ Date of Birth ____/____/____ Age _____

Name _____
First Middle Last

Address _____

Phone _____ Do I have permission to leave a message? ☐Yes ☐No

E-mail _____ Do I have permission to e-mail you? ☐Yes ☐No

Race: __ White __ Black __ Hispanic __ Asian __ Other

Ethnicity: __ Puerto Rican __ Mexican __ Cuban __ Not of Hispanic Origin Other: _____

Highest Grade Completed: _____ Hours worked per week: _____

Employment Status: __ Full-time __ Part-time __ Homemaker __ Unemployed __ Retired/Disabled

Source of Income: __Wages/Salary __ Retirement/Pension __ Public Assistance __ Self-Employment

Living Arrangements: __ Independent Living __ Dependent Living __ Homeless

Number of Children: _____ Currently Pregnant: Yes/No

Do you use Alcohol? Yes/No How many drinks per week? _____

Tobacco Use Past 30 Days: Yes/No Use of illegal drugs past 30 days: Yes/No

Have you ever been arrested? Yes/No # of Arrests: ___ Reason for Arrest(s): _____

Primary Insurance Plan (Please Circle One): Carefirst BCBS Magellan Other

Primary Policy Holder: _____ Policy #:_____ Group #:_____

Policy Holder Relationship (Circle One): Self Spouse Other:_____ Co-payment amt:_____

Deductible: _____

Secondary Insurance: _____ Policy #:_____ Group #:_____

I hereby assign all medical benefits to which I am entitled to Ben Rutt ,Ph.D. for services rendered by Dr. Rutt. This will remain in effect until revoked by me in writing. A photocopy of this assignee is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment. I hereby assume all financial responsibility for all charges whether or not paid by said insurance. I further understand that all balances are due to be paid within 30 days of receipt of statement. I agree to pay 1.5% per month's interest (18% per year) on all accounts unpaid after 30 days. I also acknowledge that this office is HIPPA compliant and that all efforts will be made to ensure my privacy, and that all records and copies of HIPPA privacy practices have been made available to me.

_____ _____
Patient Signature (or Legal Guardian) Date

EMERGENCY CONTACT

Name _____

Relationship to You _____ Phone Number _____

REFERRAL SOURCE
How did you hear about my practice? _____

REASONS FOR SEEKING SERVICES: _____

_____

_____

MEDICAL HISTORY

Do you have any medical issues that are important for me to know?_____

_____

Please note: I believe communicating with your current health care providers is important for coordination of care. However, I will not contact your current medical providers without obtaining your consent, nor will I do so before discussing this issue with you ahead of time.

Do you have a Primary Care Physician? Yes/No If Yes, please complete below

Primary Care Physician Name: _____

Primary Care Physician Practice Name: _____

Primary Care Physician Practice Address: _____

Primary Care Physician Phone Number: _____ Fax Number: _____

Do you have a Psychiatrist? Yes/No If Yes, please complete below

Psychiatrist Name: _____

Psychiatrist Practice Name: _____

Psychiatrist Practice Address: _____

Psychiatrist Phone Number: _____ Fax Number: _____

MENTAL HEALTH HISTORY

Prior Mental Health Diagnoses/Treatment: _____

_____

Have you ever been hospitalized for a mental health condition or as the result of a safety concern? ☐Yes ☐ No

If yes, please provide year, location, and reason for hospitalization: _____

_____

Are you currently in therapy? ☐Yes ☐ No If yes, with: _____

Has consultation/change in Treatment/additional therapy been discussed with current therapist? ☐Yes ☐ No

What are your goals for therapy? (If unsure, please know that we will discuss treatment goals further at our initial appointments.)

_____

_____

What stressors (if not already stated) are you experiencing currently (e.g., relational, financial, medical, occupational, legal, etc.)

_____

_____

Is there anything else you would like me to know?

_____

Please estimate the severity of your problems:

☐ mildly upsetting ☐ moderately severe ☐ severe ☐ very severe ☐ incapacitating

Please list your typical strategies for reducing stress: _____

_____

Finally, please list your greatest strengths: _____

_____

Dr. Rutt occasionally sends out information to his clients about clinical topics of interest, upcoming seminars, new services, etc. If you would like to receive this correspondence, please sign below. Also, if at any time you wish to stop receiving this information, just contact Dr. Rutt by letter, email, or phone. Thank you.

Client Signature: _____

THIS IS A BINDING CONTRACT. PLEASE READ BEFORE SIGNING

ABILITY TO PAY FORM

Client Name: _____

Fee charged for service:

Initial Assessment / CPT 90791 = $225
Therapy 30 min. session / CPT 90832 = $120
Therapy 45 min. session / CPT 90834/90853/90847 = $173
Therapy 60 min. session / CPT 90837 = $225
Fee charged for Court Appearance = $265.00 per hour
Report Preparation Fee = $165.00 per hour
Returned Check Fee = $35.00
Late cancellation fee / no show fee = $173 per hour or hourly in-network rate

I, _____, authorize Ben Rutt, Ph.D. or designated third party billing agency, holder of my medical information about me to release to my insurance company and it's agents any information needed to determine these benefits or the benefits payable to related services. Please note: Co-pay/co-insurance is subject to change at any time. For further co-pay/co-insurance information please contact your insurance company. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim.

I, _____, understand that it is my responsibility to pay for all services rendered at the time each service is provided unless otherwise agreed. **I also understand that a 24-hour cancellation notification is necessary for canceling or rescheduling an appointment. If a 24-hour notification is not given, I understand that I am required to pay the late cancellation / no show fee for my missed appointment**. I also understand that if I am seeking reimbursement for services through my insurance company that insurance companies do not reimburse for this type of fee. That fee will be charged to the following credit card:

Type of Card: VISA or MasterCard

Name on Card (must be responsible party's name): _____

Credit Card Number: _____ Exp. Date: _____

Security Code (3 digit number on back): _____ Billing Zip Code: _____

Card Holder Signature: _____

_____ _____
Client Signature Date

_____ _____
Witness Date