Dr. Lauren Gerber

Basic Information

Intake 1

Patient Name		
Street Address	City	Zip Code

Birthday	Social Security #
Home Phone	Work Phone #
Cell Phone #	
Referred By	

Bill To (Guardian or Self)		
Street Address	City	Zip Code

Birthdate	Social Security #
Home Phone #	Work Phone #
Cell Phone #	

I understand that:

- The fee for an initial one hour consultation is $350.00 (or Prorated if extended beyond 1 hour) payable at the time of the visit
- The fee for each subsequent 45 minute office visit is $300.00 or prorated if extended
- I may discuss with Dr. Gerber any concern I have about fees
- My appointments begin and end at the times scheduled
- I will be billed for appointments canceled without 24 hour notice (my insurance will not reimburse me for charges for cancelled or missed appointments)
- I am responsible for obtaining an up to date physical examination and for updating Dr. Gerber about any changes in my or the patient's heath.

In addition to fees for routine office visits, I agree to pay on a prorated basis at the hourly rate for any additional time Dr. Gerber spends providing:

- Services by telephone or other consultations directly to me or to third parties
- Written reports or letters, including insurer-required forms or other documentations
- Review of reports, records or letters
- Any additional professional services
- Travel time for consultations outside of the office

Additionally, I understand that I may be charged for:

- Returned checks
- Service fees if my account is placed with a collection agency

I agree to discuss with Dr. Gerber as soon as I may anticipate difficulty in paying fees according to the above terms. I agree to notify Dr. Gerber in writing to update information on this form immediately upon any changes.

In any case, I agree that I am personally responsible for payment in full of all fees, regardless of insurance coverage, and agree to pay these in full at the time of service or immediately upon receiving a statement.

X _____ _____

Patient's or Authorized Person's Signature Date

E-mail: info@DrLaurenGerber.com

Dr. Lauren Gerber

You may request a copy of this agreement for your records.

Intake 2

COMPLETE ONLY IF YOU PLAN TO FILE AN INSURANCE CLAIM

Insurance Plan 1

Insured's Name	Relationship to Patient
Insured's Street	
City	Zip Code
Home Phone #	Work Phone #
Birthdate	Social Security #
Insurance Company	
Submit Claims to Street	
City	Zip Code
Phone #	
Policy or ID #	Group #
Effective Date	
Group Name/Employer	

Insurance Plan 2

Insured's Name	Relationship to Patient
Insured's Street	
City	Zip Code
Home Phone #	Work Phone #
Birthdate	Social Security #
Insurance Company	
Submit Claims to Street	
City	Zip Code
Phone #	
Policy or ID #	Group #
Effective Date	
Group Name/Employer	

I will use my insurance benefits when available. I understand that Lauren Gerber, PSY.D. is a participating provider with some insurance networks. Should my insurance carrier request documentation other than the forms routinely provided, I will pay Lauren Gerber, PSY.D. for the time required for its preparation. In any event, I agree to pay all fees in full, regardless of insurance reimbursement, upon receipt of a statement from Lauren Gerber, PSY.D.

I authorize the release to my insurance carrier of medical information requested to process my claims.

_____	_____	_____
Patient's or Authorized Person's Signature	Patient's or Authorized Person's Signature	Date

E-mail: info@DrLaurenGerber.com

Dr. Lauren Gerber

Intake 3

Today's Date
Patient's Name
Address
Home Phone #
Cell Phone #
E-mail address
Date of Birth
Age

Schooling

Academic Institution
Contact Person
Grade
Highest Degree Achieved

Family Information

Mother's Name
Father's Name
Marital Status
Mother's Address
Father's Address (if different from above)
Mother's Cell Phone #
Father's Cell Phone #
Mother's Occupation
Father's Occupation
Mother's E-mail address
Father's E-mail address
Parent's Native Languages
Primary Language Spoken in Home

E-mail: info@DrLaurenGerber.com

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Sibling and Others Living in Home

Name	Age	Grade

Medical History

Illnesses in immediate family (include grandparents)

Pregnancy and Birth

Health of mother during pregnancy		
Length of Pregnancy		
Complications (if any)		
Which pregnancy was this?		
During the pregnancy did the mother experience any of the followings? (Please check all items which apply)		
☐ High Fevers	☐ German measles	☐ X-Ray Therapy
☐ Accidents	☐ Drug Therapy	☐ Bleeding
☐ Illnesses	☐ Hospitalizations	☐ Other

Any other relevant information about pregnancy or birth

E-mail: info@DrLaurenGerber.com

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Birth

Place of Birth
Birth Weight
Presentation and Delivery
Apgar Score

Check any of the following that apply to baby at birth

☐ Jaundiced	☐ Blue	☐ Marked or scarred
☐ Incubated	☐ Transfused	☐ Other

Medical

Current Health
Under Treatment for the following
Primary Care Physician
Psychiatrist

Previous Medical History

Please specify date or age at which patient experienced any of the following

Accidents (please describe)
Chicken Pox
Childhood Illness
Dizziness
Ear Aches (frequent)
Measles
Head Injury
High Fevers
Mumps
Pneumonia
Scarlet Fever
Tonsillitis
Whooping Cough
Other (please describe)
Motor Development
Handedness
Right ☐
Left ☐
Ambidextrous ☐
Surgery
Hospitalization

E-mail: info@DrLaurenGerber.com

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Please state the problem as you see it and feel free to add additional relevant information

Patient Description (check those which apply)

☐ Active	☐ Affectionate	☐ Dependent
☐ Empathetic	☐ Fearful	☐ Flexible
☐ Follower	☐ Happy	☐ Leader
☐ Moody	☐ Outgoing	☐ Sad
☐ Stubborn	☐ Other	☐ Anxious

Treatment History

Medications currently taking

Medication	Dosage	Prescribed By

Therapies/Treatments

(Educational, Psychiatric, Psychological, P.T., O.T. Speech etc…)

Type	Frequency	With Whom?

Evaluations

Type	**Date**
Case Study Evaluation	
Neurological Evaluation	
Psychiatric Evaluation	

Person Completing Questionnaire (printed)
Person's Signature
If not patient, relationship to patient

Person completing this form has done so honestly and to the best of their ability; and has been given a copy of the Dr. Lauren Gerber HIPPA policy.

E-mail: info@DrLaurenGerber.com