**PRE-CONSULTATION QUESTIONNAIRE**

**NAME:**

**DATE OF BIRTH:**

**ADDRESS:**

**HOME PHONE NUMBER:**

**CELL PHONE:**

**WORK NUMBER:**

**EMAIL:**

**EMERGENCY CONTACT:**

**INSURANCE PLAN WITH ID NUMBER:**

**TIMES YOU COULD COME ON WEEKDAYS:**

**OCCUPATION:**

**SCHOOL/EMPLOYER:**

**REFERRED BY:**

Please summarize briefly why you are seeking treatment at this time (please indicate if you are interested in medication management with psychotherapy, or medication management only):

Please list current psychiatric medications, and your response to them:

Please list past psychiatric medications, and your response to them:

Please list any past psychiatric hospitalizations or residential treatment:

Have you ever intentionally tried to harm yourself or another person?

Please list any active or past medical problems, including substance abuse, and any non-psychiatric medications you are taking:

Please describe any history of mental health problems in blood relatives on either side of your family, including past and current psychiatric medications and response to them:

If patient is a child, who has legal custody for decisions regarding treatment, including medications if needed?

Is there any history of legal problems or agency involvement?

**Consent for Release of Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize clinical communication between

Dr. Mark Strecker and: (*fill in all that apply*). Communication may include direct verbal communication, clinical documentation including in-patient and out-patient treatment notes, discharge summaries, testing and laboratory results, and similar clinically relevant materials. I understand that I may withdraw this consent at any time by submitting a request in writing to Dr. Strecker.

PCP/pediatrician:

Address:

Phone Number:

Psychiatrist:

Address:

Phone Number:

Individual therapist:

Address:

Phone Number:

Family therapist:

Address:

Phone Number:

Any Past Psychiatric Hospitals or Residential Treatment Programs:

Address:

Phone Number:

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

**Policies and Terms of Treatment**

[ ] Please type or sign your initials to indicate agreement with the following:

**[ ] Fees and Payment**: Dr. Strecker accepts insurance from the all Blue Cross/Blue Shield.plans, except those that are through the Massachusetts Health Connector or Mass Health. Some plans will reimburse a portion of fees paid to "out-of-network" providers. I will also see patients who want to pay out of pocket, based on my hourly rate. Payment of any applicable co-payment or deductible is due at the time services are rendered, by cash, check or credit card.

Some services may not be covered by health insurance.  Charges for uncovered services will be your responsibility.  This may include charges for telephone consultation, written correspondence, or reports in connection with your evaluation or treatment. Limited telephone consultation is part of routine patient care and is undertaken without charge. However, when extensive telephone consultation or other than routine written correspondence or reports are requested or required, a charge for these services will be applied, based on both the length and complexity of the call.

These charges will be your responsibility as they are generally excluded from coverage by health insurance plans. The minimum rate for these charges will be $400/hour. There will be no charge for calls that result in your being psychiatrically hospitalized, or regarding what I consider to be urgent questions regarding potentially serious side effects of your medication.

You should call your insurance company yourself to learn exactly what your mental health benefits are (they are often different from other medical benefits).  If your insurance policy changes, you need to email me to inform me of your new policy, and bring your new insurance card with you to your next appointment; otherwise you will be charged the full fee.

Most policies have a limit to how long after an appointment the service can be billed to the insurance.  Therefore, if you fail to notify me of a change in your health insurance policy in a timely manner, you will be responsible for the full fee.

**[ ] Appointment Cancellations/Rescheduling**

My cancellation policy requires that you **email** me at least 48 hours in advance of the appointment in order to avoid being charged. Please state alternatives days/times in your email that would work for you to reschedule.  Do not phone me to cancel or reschedule. If the appointment is on a Monday or following a long weekend, the cancellation should be made before noon on the previous working day.

Insurance generally does not cover charges for missed appointments or late cancellations.  The full fee for missed appointments or late cancellations is your responsibility, and must be paid at or before the next visit.

Thank you for filling out this questionnaire. Please return to Dr. Mark Strecker by:

***Email*:** [mstrecker@drmarkstrecker.com](mailto:mstrecker@drmarkstrecker.com)

***Secure fax:*** 888-315-3476

***Mail:*** 76 Bedford Street, Suite 12, Lexington, MA 02420

Dr. Strecker will respond by email or phone with confirmation of your appointment time.