

Completion of this form in its **ENTIRETY** is required at the time of the visit. **PATIENT INFORMATION**

Last name:			
First name:			
Middle name:			
Address:			
City: St	ate:	Zip code:	
Cell phone number:			
Work phone number:			
Social security number:			
Date of birth:			
Age:			
Male/Female (circle one)			
Marital Status:			
Occupation:			
Name and address of employer:			
P	ATIENT'S SPOUSE	INFORMATION	
Last name:			
First name:			
Middle name:			
Home phone number:			
Work phone number:			
Cell phone number:			
Social security number:			
Date of birth:			
Occupation			
PERSON ASSUMING	G FINANCIAL RES (person signing	PONSIBILITY FOR THE PATIENT (this form)	
Last name:			
First name:			
Address:			
City:	State:	Zip code:	
Social security number:			
Home phone number:			
Work phone number:			
ell phone number:			

Occupation:		
Employer's name:		
Employer's address:		
City:	State:	Zip code:
Employer's phone number:		<u>-</u>
Relationship to patient:		
	INSURANCE INFO	
Name and address of primary insurance co	ompany	
		
Policyholder's first and last name:		
Policyholder's date of birth:		
Policyholder's employer:		
Policy number:		
Group number:		
Policyholder's relationship to patient:		
LOCAL EDIEND	OD DEL ATIVE O	THER THAN LISTED ABOVE
Name:		
Address:	State:	Zip code:
Phone number:		
Relationship to patient:		
relationship to patient.		
	REFERRE	D BY
Patient's primary care physician:		
Referred to me by:		
Reason for referral:		
Previous therapy?		
If so with whom?		
I hereby authorize Dale B. Mortimer, company on my behalf for all services. company with any/all information reques	M.D., P.C. to bill m I hereby authorize D sted concerning my p	ND ASSIGNMENT OF INSURANCE BENEFITS. y insurance company and accept payment from that bale B. Mortimer, M.D., P.C. to provide my insurance present claims relating to my care. I acknowledge that I t covered by my insurance.
Responsible party's signatu	ıre:	Date:
AUTHORIZATION TO PRO	OVIDE REASONAB	BLE AND PROPER MEDICATION CARE
Patient's signature:		Date:



Dale B. Mortimer, M.D., P.C.

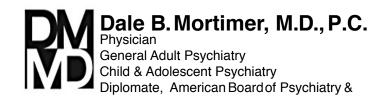
Physician
General and Adult Psychiatry
Child and Adolescent Psychiatry
Diplomate, American Board of Psychiatry and Neurology

Completion of this form in its **ENTIRETY** is required at the time of the visit.

PATIENT INFORMATION			
Last name:			
First name:			
Middle name:			
Address:			
City:	State:	Zip code:	
Phone number:			
Social security number:			
Date of birth:			
Age:			
Male/Female (circle one)			
PAT	ΓΙΕΝΤ'S FATHERS IN	NFORMATION	
Last name:			
First name:			
Middle name:			
Address:			
City:	State:	Zip code:	
Previous address (if less than 3 years):			
Home phone number:			
Work phone number:			
Cell phone number:			
Social security number:			
Date of birth:			
Marital status:			
Occupation:			
Employer's name:			
Employer's address:			
City:	State:	Zip code:	
Employer's phone number:			
PAT	TIENT'S MOTHERS I	NFORMATION	
Last name:			
First name:			
Middle name:			
Address:			
City:	State:	Zip code:	
Previous address (if less than 3 years):			
Home phone number:			
Work phone number:			
Cell phone number:			
Social security number:			

Date of birth:		
Marital status:		
Employer's name:		
Employer's address:		
City:	State:	Zip code:
Employer's phone number:		
PERSON ASSUMI	NG FINANCIAL RESPONS (person signing this f	SIBILITY FOR THE PATIENT form)
Last name:		
First name:		
Address:		
City:	State:	Zip code:
Previous address (if less than 3 year	s):	
Date of birth:		
Marital status:		
Home phone number:		
Work phone number:		
Cell phone number:		
Occupation:		
Employer's name:		
Employer's address:		
City:	State:	Zip code:
Employer's phone number:		
Relationship to patient:		
Name and address of primary insura	INSURANCE INFORMance company	
Insurance company phone number:		
Policyholder's first and last name:		
Policyholder's date of birth:		
Policyholder's employer:		
Policy number:		
Group number:		
	ND OR RELATIVE OTHE	
Name:		
Address:		
City:	State:	Zip code:
Phone number:		
Relationship to patient:		
	REFERRED BY	
Patient's primary care physician:		
Referred to me by:		
Reason for referral:		

Previous therapy?	
If so with whom?	
AUTHORIZATION TO RELEASE INFORMATION AND	ASSIGNMENT OF INSURANCE RENEFITS
I hereby authorize Dale B. Mortimer, M.D., P.C. to bill my chil	
that company on my child's behalf for all services. I hereby aut	
child's insurance company with any/all information requested c	
his/her care. I acknowledge that I am responsible for all charges	
	• •
Responsible party's signature:	Date:
AUTHORIZATION TO PROVIDE REASONABLE AND I	PROPER MEDICATION CARE
D	D .
Parent or legal guardian signature:	Date:



TREATMENT CONTRACT WITH DALE MORTIMER, M.D., P.C.

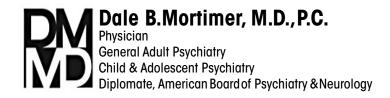
As part of my written treatment contract with Dr. Mortimer, I understand that Dr. Mortimer will do his best to provide the patient indicated below with competent medical/ psychiatric treatment. In return, I promise to make treatment with Dr. Mortimer a very high priority. Among other things, this means:

- 1. The patient will keep all appointments with Dr. Mortimer and will arrive in his office on time (earlier is better);
- 2. The patient will follow-through with the agreed-on treatment plan;
- 3. The patient will abstain from all marijuana, alcohol, cocaine, hallucinogens and other non-prescribed substances of abuse;
- 4. The patient will establish and/ or maintain a professional relationship with a primary care physician;
- 5. The patient makes an inviolable commitment to no self-harm;
- 6. The patient will make a sincere effort to be as truthful, honest and candid with Dr. Mortimer as he or she can be;
- 7. The patient (or the parent/ guardian) will keep any medication that Dr. Mortimer prescribes for the patient in a safe location which is secure from theft and diversion;
- 8. The patient will take all medications prescribed by Dr. Mortimer as directed;
- 9. The patient agrees to honor and obey all laws; and
- 10. The patient (or the parent/guardian) will notify Dr. Mortimer right away if any of the above treatment contract conditions will not be met.

I understand that while Dr. Mortimer cannot make any guarantees regarding a successful treatment outcome. However, I also understand that he will do his best to provide the patient with competent medical/ psychiatric treatment.

I understand the above conditions of the treatment contract with Dr. Mortimer for the patient listed below, and I hereby promise to honor the treatment contract as outlined above.

Name of patient:	
Signature of patient or parent/guardian:	Date:
Dr. Mortimer's signature:	Date:



FEE SCHEDULE (effective date: 2/20/2018)

In January 2013, there were major changes made in the physicians' procedural terminology (CPT) codes to more accurately and fairly reflect the psychiatrists' time and cognitive work involved in evaluating and treating their patients. To wit: these most recent revisions in the CPT codes are an attempt to correct the systematic and unjust devaluing of psychiatrists' professional medical and psychotherapeutic services by far too many medical insurance carriers. Do keep this Fee Schedule as a reference for interpreting both my billing statements and your medical insurance carrier's Explanation of Benefits ("EOB"). The CPT is a listing of descriptive terms and codes used by physicians to report the medical and psychiatric services and procedures that physicians provide for the benefit of their patients. [E&M: "medical evaluation and management"]

	Physicia 99205 99245 99213 99214 99215	Diagnostic evaluation, new patient (first hour of assessment) Psychiatric/ medical consultation, new patient, with report to referring physician Office visit, medical evaluation and management, 13–20 minutes Office visit, medical evaluation and management, 21–32 minutes Office visit, medical evaluation and management, 33 or more minutes	Fees \$635 \$800 \$375 \$440 \$570
	+90785 +90833 +90836 +90838 +99050 +99354 +99355	[E&M] Plus "interactive complexity", (e.g., young patient; family members present; schools involve [E&M] Plus psychotherapy as part of – not in addition to – the office visit, 16–37 minutes [E&M] Plus psychotherapy as part of – not in addition to – the office visit, 38–52 minutes [E&M] Plus psychotherapy as part of – not in addition to – the office visit, 52 or more minutes Professional medical services outside normal business hours in addition to basic service Prolonged face to face contact: first 60 minutes Prolonged face to face contact: next 30 minutes beyond first hour Review extensive records, before or after office visit without patient, first 60 minutes	yed) \$65 \$120 \$190 \$300 \$155 \$255 \$240 \$275
	Professi 90889 99011 99080 99441 99442	onal Services Not Usually Covered By Insurance Special report prepared by Dr. Mortimer for an agency or for another physician Broken appointment (without the required 2 working days' notice) Special report prepared by Dr. Mortimer at patient's or family's request Phone call from patient or family to Dr. Mortimer; 5–10 minutes of medical discussion; pull and review patient's medical record, document content of call and clinical decision–making rational Phone call from patient or family, 11-20 minutes of medical discussion; pull and review chart Phone call from patient or family, 21-30 minutes of medical discussion; pull and review chart	\$635/hr \$635/hr \$635/hr \$60 \$120 \$180
((Unoffici 00000 0002 0003 0005 0006	No show for scheduled office visit: charges based on office time reserved Broken appointment, with less than required two full working days' notice Patient–initiated prescription refill processing (pull patient chart, review medical record, write prescription or complete fax authorization, arrange for prescription pick up, make medical chart note) without accompanying office visit Patient's insurance–initiated prescription prior authorization request processing by Dr. Mortimer Returned ("bounced") check fee	\$630/hr \$630/hr \$65 \$65 \$65

I have received a copy of this fee schedule: