***Mark S. Schwartz, Ph.D****.*

Clinical Psychologist

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\_\_/\_\_\_/2015

MSS ID#: \_\_\_\_ \_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

BCBS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or

VA AUTH #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or

Self-pay \_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SESSION FORM

TOTAL PAYMENT DUE:

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Patient Today’s Patient Payment Check#

Balance Charges Co-pay/Co-Ins/Deductible Cash/Check/PayPal/VA

$ \_\_\_\_\_ $ \_\_\_\_\_ $ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

CPT

**90791** \_\_\_\_ **Initial Psychological Evaluation 96101 \_\_\_\_ Psychological Testing (units)**

**90837 \_\_\_\_ Psychotherapy (60 min.) or 90834 \_\_\_\_\_ (45 min.) or 90832 \_\_\_\_\_\_ (30 min.)**

**90839 \_\_\_\_\_ Crisis (1st 60 min.); 90840 \_\_\_\_\_\_ (+ each 30 min.)**

90876 (60 minutes) \_\_\_ Individual psychophysiological therapy with psychotherapy (face-to-face)

90875 (20-30 minutes) \_\_\_ Individual psychophysiological therapy with psychotherapy (face-to-face)

**96150**  \_\_\_\_ Behavioral Health Assessment – Initial **96151 \_\_\_\_** Re-assessment

**96152**  \_\_\_\_ Behavioral Health Intervention

90847 \_\_\_\_ Family Therapy - patient present \_\_\_\_ Family Therapy - patient not present

\_\_\_\_ Phone call 15-30 minutes \_\_\_ Phone call 30-45 minutes \_\_\_ Phone call 45-60 minutes

\_\_\_\_ Special Letter \_\_\_ No Show/Late Cancel

Diagnosis codes: \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Comments:

Next Appointment Date(s) \_\_\_\_\_\_\_ Time \_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ Time \_\_\_\_\_\_

I authorize payment due to me to be made directly to: Mark S. Schwartz, Ph.D.

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 (Signed by Patient or Legal Guardian) Provider: Mark S. Schwartz, Ph.D.