Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name		Last Name (as it appears on insurance card or ID)	
Sex	Marital Status	Date of Birth (Age)		Social Security Number	
Patient's Address		City	State	Zip	
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number
Insured's Address		City	State / Zip
Insured's Social Security Number	Insured's Birthdate		

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient
Address		City	State / Zip

_____ _____

Signature of Patient or Authorized Guardian Date

Name _____ Gender _____ Age _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Women Only:

# of Pregnancies	# of Miscarraiges	# of Abortions	# of Living

Last Pap Smear	Last Mammogram	Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details:

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

DAVID H. LIFSCHUTZ, M.D.

Diplomate, American Board of Psychiatry and Neurology (P)

PATIENT-PHYSICIAN AUTHORIZATIONS AND AGREEMENTS

Authorizations and agreements with David H. Lifschutz, M.D.

Please read carefully and sign. The paragraphs below contain several agreements.

For:

_____

Print Patient's Name

Medical Insurance: I authorize the medical insurance company to pay directly for the above physician's services. I, however, understand that both I and/or the person who signs below are responsible for all my fees, including any fees not paid by the insurance company.

_____

Patient or parent signature

Release of Information: I authorize David H. Lifschutz, M.D., to release information about me to the medical insurance company and the referring physician. This authorization will end if I give written instructions to Dr. Lifschutz, to that effect, which I may do at any time.

_____

Patient or parent signature

Financial Responsibility: We, the undersigned, understand and agree that each of us is responsible for the patient's fees to David H. Lifschutz, M.D., including any fees not paid by medical insurance, and that we are responsible for full therapy fees resulting from appointments not kept or cancelled without a 24 hour notice.

_____

Patient or parent signature Date

_____

Responsible party's signature Date

David H. Lifschutz, M.D. *Psychotherapy/Psychopharmacology*

17 East 97th Street, Ste #1C Tel (212) 529-2733
New York, N.Y. 10029 Fax (212) 529-1042

HIPAA CONSENT FORM

Our Notice of Privacy Practices information is about how we may use or disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- This Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I have been informed by you of your Notice of Privacy Practices and I have been given a right to review it before signing this consent. I also was provided with a copy. I hereby, knowingly and voluntarily authorize the Practice to use or disclose my health information in the manner described above.

This Consent was signed by: _____
Please print Name (If you are the patient)

Signature_____ Date_____

Witness:_____ Date_____

Patient's name_____ Date of Birth_____

Financial Policies, please initial to acknowledge each policy:

_____In the event off returned ACH or a declined credit/debit charge, patient's account will be charged a $30.00 service fee for each occurrence if the account is not paid in full within 48 hours of notification to Patient/Guarantor by David H. Lifschutz, MD via phone/email/text.

_____Patient/Guarantor must update expiring or invalid cards if a credit card is stored on file.

_____Past due accounts will incur $50.00 if 7 days past due, $75.00 for 30 days past due, and $100 for 60 days past due at which time bill will be sent to collections.

_____Fees are due at time of service unless a credit card is stored on file.

_____Any outstanding balance is due at beginning of appointment and if insufficient funds, appointment rescheduled.

_____Dr. Lifschutz is a sole practitioner with limited staff. This allows him to personalize care without constraints of organizations; however, also because of this, the doctor cannot offer individualized payment plans or sliding scales.

_____For new patient appointments, a $150.00 deposit is required to hold the appointment. Payment can be made through our website . Three business days are required to cancel or reschedule new patient appointments to prevent forfeit of deposit.

For established patients, missed appointments or late cancellations without 72 hours notice (3 business days outside of weekends) will be billed at the full rate of the scheduled appointment.

_____Dr. Lifschutz only currently bills Aetna Insurance and has limited number of spaces for these patients. He is out of network for all other insurance companies, but the doctor will provide a transaction receipt and a paid statement to the patient/guarantor to be mailed to you after your appointment. You may submit these documents to your insurance company for potential reimbursement depending on your coverage. if you have special requests for how or where to deliver your statement please contact out office. Some questions to ask your insurance company:

1) What are my out-of-network benefits for Psychiatric services with a Medical Doctor?
2) What percentage of my cost is covered after I meet my deductible?
3) How do I get reimbursed>
4) What are the allowable rates?
5) How does that effect reimbursement?

Weekly therapy patients are asked to give several weeks notice for anticipated absences.
If >3 therapy sessions are missed in a12 months without advanced notice, you will be asked to hold your spot with payment weekly regardless of attendance or forfeit your time slot.

_____If a valid credit card is not stored on file then fees can be paid by credit/debit card/cash/check/paypal at the start of the appointment. Storing of your payment information for automatic billing is preferred because handling of payments during session can decrease the amount of time available for patient care.

_____Special fees may be incurred for extended phone calls, document preparation, level cases, medical record handling. See fee sheet includes in this document for a complete list of fees.

Patients or responsible party
Signature_____

Date_____ 3/26/18