Patient Information **(Must Be Completed Before Services can be Rendered)**

NAME: _____
First Middle Last

ADDRESS: _____
Street Apt. # City State Zip

PHONE: Work _____ Home _____

SOCIAL SECURITY: _____ Sex: _____ Male _____ Female

MARITAL STATUS _____ DATE OF BIRTH: _____
Month/Day/Year

EMPLOYER: _____

EMPLOYER ADDRESS: _____

Responsible Party / Spouse / Parent Information

NAME: _____

ADDRESS: _____

PHONE: Work _____ Home _____

Primary Insurance
NAME OF CARRIER: _____

ADDRESS: _____ PHONE: _____

NAME OF INSURED: _____ Group _____ ID# _____

DATE OF BIRTH OF INSURED _____ Social Security of Insured _____

Secondary Insurance
NAME OF CARRIER: _____

ADDRESS: _____ PHONE: _____

NAME OF INSURED: _____ Group _____ ID# _____

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Release of Authorization/Assignment of Benefits

I authorize the release of any medical/psychological information necessary to process my insurance claims. I authorize and request payment of medical benefits directly to my psychiatrist. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment. I understand and agree to pay for missed appointments not canceled with 24 or more hours notice.

Signed _____ Date _____

The receptionist will need to copy your insurance cards and drivers license. Please present them to the receptionist with this completed form. Thank you.

ARUN A. POL, M.D., P.C.-OFFICE POLICIES/ FINANCIAL POLICY/CONSENT FOR TREATMENT

- Your **co- payment/ deductible is due at the time of service**, before we can file a claim on your behalf with the Insurance company. There cannot be any exceptions to this. Failure to pay may result in your visit being rescheduled.
- **Mental Health benefits differ from your Medical benefits** and may have different co-payments and deductibles. You must **verify your benefits with your Insurance company, obtain authorization** before your initial visit and every time there is a change in your Insurance coverage.
- It is your responsibility to **bring in your Insurance card at each visit** and to **notify us of any change in Insurance coverage** (including any additions or deletions in Insurance plans), prior to your next visit. If you submit a new Insurance card at the time of a follow-up visit, your visit may be rescheduled so we can verify your coverage / obtain necessary authorizations from your Insurance company for the visit.
- If your Insurance has lapsed or your Insurance information is not correct, you will be responsible for all charges for the visit.
- Please **notify us of any change** in your Address & / Telephone number immediately.
- A **10 $ service fee** may be added to any unpaid balances.
- If the **' amount due' / previous balances remain unpaid**, despite repeated billing then **treatment may be terminated** and you may be referred to another Psychiatrist.
- We will file the claim with your Insurance company for you, if we are a participating provider for your plan.
- You will be responsible for payment for any all services in excess of your Insurance limits, as well as non-covered services.
- Your **check out statement** includes amount due for the current visit and any previous balance (which has been calculated after receiving an EOB- Explanation of Benefits from your Insurance Company, after we filed claims on your behalf for prior visits) or previous co-payments / deductibles not paid by you. If you dispute the amount due, you need to contact your Insurance Company to clarify the matter.
- For a **child living in two separate households** , the parent / guardian that brings the child for the appointment is responsible for the payment at the visit.
- We may **charge for missed late canceled appointments** (less than 48 hrs. notice) (fee of 50 $).
- **Fee for Bounced checks is 35 $,** paid by cash or credit /debit card.
- There is a **fee for transfer / copying of Medical records**, for transcription of records, / completion of any disability papers, payable prior to the execution of such a request. The fee for the same depends on the amount of work involved.
- There may be **fee charged for the time spent in collaborative treatment planning** with your therapist / physician / attorney. You will be informed if such a charge will be applied prior to such a discussion.
- Your initial visit is for a Diagnostic Evaluation. Subsequent visits are for medication management. You will be referred to a therapist if that is needed in your case.
- 48 hour notice is required for prescription refills. Lost prescriptions for controlled substances including stimulants will not be replaced.
- Routine messages can be left on the voice mail. Dr. Pol can be paged for emergencies.
- We use the services of Alpha Omega Medical Management to file your claim with the Insurance Company and bill you for any balances.
- Unpaid amounts after repeated billing may be referred over to Collections.

_____ _____ _____

Patient/ Guardian Signature Patient Name Date

ARUN A. POL, M.D., P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for ARUN A. POL, M.D., P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (ARUN A. POL, M.D., P.C. 's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. ARUN A. POL, M.D., P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to ARUN A. POL, M.D., P.C.

With this consent, ARUN A. POL, M.D., P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent ARUN A. POL, M.D., P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that ARUN A. POL, M.D., P.C. restrict how it used or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to ARUN A. POL, M.D., P.C. 's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, ARUN A. POL, M.D., P.C. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I, _____ (Patient Name – Please Print), _____ (Patient Identification Number), _____ (Patient Date of Birth - MM/DD/YYYY)

authorize _____ (Provider Name – Please Print), to release protected health information related to my evaluation and treatment to:

PCP Name: _____ **PCP Phone:** _____

PCP Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Information to be completed by Behavioral Health Provider

I saw _____ (Patient Name – Please Print) on _____ (Date) for _____ (Reason / Diagnosis)

Summary: _____

The following medication was or will be started (indicate medication & dosage): _____

If no medication is indicated, check as appropriate:

_____ Medication not prescribed _____ Patient refused medication _____ Psychotherapy suggested before trying medication

Treatment recommendations:

Lab tests for the following: _____ CBC _____ Thyroid Studies _____ Chem Panel _____ EKG

Other treatment recommendations: _____

If you have any questions or would like to discuss this case in greater detail, please call me at: _____ (Phone Number)

_____ (Provider Signature) _____ (Provider Printed Name) _____ (Licensure)

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting:

_____

- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization: PATIENT PLEASE CHECK ONE

_____ To release any applicable mental health / substance abuse information to my primary care physician.

_____ To release only medication information to my primary care physician.

_____ I DO NOT give my authorization to release any information to my primary care physician.

_____ (Patient Signature) _____ (Date) _____ (Signature of Patient's Authorized Representative) _____ (Date)

If signed by Authorized Representative, describe relationship to patient: _____

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREAMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

6/03