

# Staten Island Medical and Behavioral PC.

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## Patient Intake form

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM / DD / YYYY

### Section 1

### Demographics

Name: \_\_\_\_\_  
(First Name) (MI) (Last Name)

Gender:  Female  Male  Other \_\_\_\_\_

Tel: (Home) \_\_\_\_\_ Tel: (Mobile) \_\_\_\_\_ Email: \_\_\_\_\_

Tel (Work): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Place of residence:  House  Apartment  Share Room Others

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ (years) SS# |\_|\_|\_|-|\_|\_|-|\_|\_|\_|\_|

Height: \_\_\_\_\_ Feet/ Inches

Weight \_\_\_\_\_ lbs.

#### Ethnicity:

Hispanic or Latino  Not Hispanic or Latino

#### Race:

- White  Black or African American  Asian  American Indian or Alaska Native  
 Native Hawaiian or Other Pacific Islander.  Other Race  More than one race (Multiracial)  
 Unknown / Not reported

Highest Level of Education Completed:  Elementary  Some High School  High School Graduate

Associate's degree  bachelor's degree  Post Graduate Degree  No formal education

Employment Status: Occupation/Job Title: \_\_\_\_\_

Employed Full time  Employed Part Time  Unemployed  Retired.  Student  Disability

Household income per year: \_\_\_\_\_  I do not want to disclose it

Marital Status:  Single  Married  Divorced  Separated  Widowed  Living with partner

How many Children do you have?

Boys: \_\_\_\_\_ ages: \_\_\_\_\_ Girls: \_\_\_\_\_ ages: \_\_\_\_\_

How many siblings do you have?

Brothers: \_\_\_\_\_ ages: \_\_\_\_\_ Sisters: \_\_\_\_\_ ages: \_\_\_\_\_

**Section 2 Insurance Information**

**How are you going to pay for the doctor's visit?**

- I will pay out of pocket. [skip Insurance information]:
- I have insurance other than Medicaid. [We do not accept Medicaid].

**Primary Insurance (Subscriber's Information)**

Insurance Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_  
(First Name) (Last Name)

Date of Birth: \_\_\_\_\_

Relationship: \_\_\_\_\_

Your Ins. ID# \_\_\_\_\_

Subscriber's ID# \_\_\_\_\_

Subscriber Phone No. \_\_\_\_\_

Your Copayment: \_\_\_\_\_

**Secondary or Supplemental Health**

Insurance Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_  
(First Name) (Last Name)

Date of Birth: \_\_\_\_\_

Relationship: \_\_\_\_\_

Your Ins. ID# \_\_\_\_\_

Subscriber's ID# \_\_\_\_\_

Subscriber Phone No. \_\_\_\_\_

**SECTION 3 PROVIDER'S INFORMATION**

**Primary Health Care Provider:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Tel No:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Email:** \_\_\_\_\_

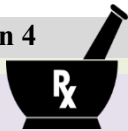
**Previous Psychiatrist:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Tel No:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Section 4 PHARMACY INFORMATION**



*Pharmacy*

Name: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Section 5 Smoking & Alcohol**

**Tobacco/vape history**       Non-Smoker       Smoker

**If smoker:** How many cigarettes per day/Week/Month? \_\_\_\_\_

**If nonsmoker:** How many years since stopped smoking? \_\_\_\_\_

**Alcohol History:**  Nonalcoholic  Social drinker  Heavy drinker. Number of drinks/days? \_\_\_\_\_

**Section 6 Illicit Drug History**

Any history of recreational/street drug use?       No       Yes \_\_\_\_\_

If "No" Skip to next section No.

Drugs (Please Check all that apply)	Start Date	Dose (How much)	How often	Stop Date	Out come
<input type="checkbox"/> Cocaine					
<input type="checkbox"/> Crack cocaine					
<input type="checkbox"/> Heroin					
<input type="checkbox"/> Methamphetamine (meth)					
<input type="checkbox"/> ecstasy					
<input type="checkbox"/> Hallucinogens					
<input type="checkbox"/> marijuana (in some states)					
<input type="checkbox"/> inhalants					
<input type="checkbox"/> prescription drugs (when sold without a prescription)					
<input type="checkbox"/> <b>Opioids</b> <input type="checkbox"/> Codeine <input type="checkbox"/> Fentanyl <input type="checkbox"/> Hydrocodone	<input type="checkbox"/> Hydromorphone <input type="checkbox"/> Meperidine				
<input type="checkbox"/> Amphetamines <input type="checkbox"/> Dexedrine <input type="checkbox"/> Adderall <input type="checkbox"/> Ritalin	<input type="checkbox"/> Methadone <input type="checkbox"/> Morphine <input type="checkbox"/> Oxycodone <input type="checkbox"/> Oxymorphone				
<input type="checkbox"/> Barbiturates Seconal, Nembutal, phenobarbital, and Pentothal. Barbiturates such as Quaaludes, and Rohypnol					
<input type="checkbox"/> Benzodiazepines					
<input type="checkbox"/> Over-The-Counter Drugs <input type="checkbox"/> motion sickness drugs (dimenhydrinate) <input type="checkbox"/> cold medicines. (Pseudoephedrine)					
Others					

**Section 7**

**Lab Tests**

When was your last blood lab done? \_\_\_\_\_ Name of the lab: \_\_\_\_\_

**Section 8**

**Referral**

**How did you hear about us?**

- Psychology Today  Insurance  Web search (simbpc.com)  Social Media \_\_\_\_\_
- Referred by a physician (Name): \_\_\_\_\_
- Referred by a Therapist (Name): \_\_\_\_\_
- A friend (Name of the friend) \_\_\_\_\_
- Returning Patient
- Other: \_\_\_\_\_

**SECTION 9**

**What is the reason for your visit today?** \_\_\_\_\_  
\_\_\_\_\_

When did your symptoms start? (date) \_\_\_\_\_

When were you diagnosed: \_\_\_\_\_

Do you see or feel things which other people cannot see?  No  Yes

**If yes**, please explain what you see or hear \_\_\_\_\_

Do you have some beliefs which are odd for other people?  Yes  No

**If yes**, please explain \_\_\_\_\_

Do you have a thought to hurt yourself?  Yes  No

**If yes**, what was the intensity of such thoughts  Mild fleeting thoughts  Moderate  Severe

Do you have a plan to hurt yourself?  Yes  No

**If yes**, what is your plan? \_\_\_\_\_

Is there any reason which prevents you from hurting yourself?  Yes  No

**If yes**, what is your plan? \_\_\_\_\_

Did you ever have fleeting thought of hurting yourself?  Yes  No

Did you ever have thoughts of hurting others?  Yes  No

Have you ever been to **an EMERGENCY ROOM or hospitalized for psychiatric reasons?**  Yes  No

**If yes**, please describe:

Date of visit: \_\_\_\_\_

Reason of visit \_\_\_\_\_

For how long were you admitted in the ER? \_\_\_\_\_

For how long were you admitted in the hospital? \_\_\_\_\_

Were you hospitalized for psychiatric reasons?  Yes  No

Name of the hospital: \_\_\_\_\_

Address of the hospital: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel No. \_\_\_\_\_

What was the diagnosis. \_\_\_\_\_

What was the medication used during your stay at the hospital?

When were you discharged? (Date) \_\_\_\_\_

Are you taking any Psych medication  Yes  No If "yes" please mention their names doses?

#	Name of medication	Dose e.g., Unit (mg) once/twice/thrice	Start Date	Stop Date	Comments
1					
2					
3					
4					
5					

(Attach a separate list of medication if necessary)

**Section 10 Medical History**

**Medical History:**

- High Blood Pressure  High Cholesterol  Diabetes  Thyroid  Hyperthyroid  Hypothyroid  
 Palpitation  Headaches/ migraine  Others: \_\_\_\_\_

Any medical/surgical procedures done in the past?  No  Yes

If yes, please explain: \_\_\_\_\_

**Section 11 Allergy History**

Are you allergic to any Medication/Food?  Yes  No

If "yes" name, the medication/Food \_\_\_\_\_

By signing below, you certify that:

- 1) All the information is correct to the best of your knowledge.
- 2) You have provided copies of your:
  - a. A copy of your health insurance card and
  - b. A copy of your photo ID (driving license).
  - c. Last blood work-up report done within past six months.

**Section 12 Informed Consent**

This form describes Patient Telehealth treatment and payment policies and includes:

- Your consent to receive medical treatment from SIMBPC (Staten Island Medical and Behavioral P.C.)
- Your agreement to receive services using telehealth technology; and
- Your agreement to pay in full any charges that are your responsibility.

I understand and agree that I am signing this Consent that

- (i) I have reviewed, understand, and accept the risks and benefits of telehealth services as described below and wish to receive such services, and
- (ii) I agree to the remaining terms of this Consent, including the terms of the Staten Island Medical & Behavioral Health Privacy Notice described below.

1. By using the **Doxy.me** telehealth portal, I agree to receive telehealth services. Telehealth involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and

data communications. During my visit, my provider and I will be able to see and speak with each other from remote locations.

2. I understand and agree with that:

- I will not be in the same location or room as my medical provider.
- My provider is licensed in the state in which I am receiving services. I will report my location accurately during registration.
- Potential benefits of telehealth (which are not guaranteed or assured) include:
  - (i) access to medical care if I am unable to travel to my provider's office.
  - (ii) more efficient medical evaluation and management; and
  - (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff, and other individuals at a physical location.
- Potential risks of telehealth include:
  - (i) No availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist Staten Island Medical and Behavioral P.C.'s medical provider in diagnosis and treatment.
  - (ii) Staten Island Medical and Behavioral P.C. provider's inability to conduct a hands-on physical examination of me and my condition; and
  - (iii) Delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold my Staten Island Medical and Behavioral P.C. and provider responsible for lost information due to technological failures.
  
- I further understand that my Provider's advice, recommendations, and decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me.
- I understand that my provider relies on information provided by me before and during our telehealth encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.
- I may discuss these risks and benefits with my Staten Island Medical and Behavioral P.C. provider and will be given an opportunity to ask questions about telehealth services.
- I have the right to withdraw this consent to telehealth services or end the telehealth session at any time without affecting my right to present or future treatment by my Staten Island Medical and Behavioral P.C. provider.
  
- I understand that the level of care provided by my Staten Island Medical and Behavioral P.C. provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be referred to the hospital emergency department or other appropriate health care provider.

3. I consent to, understand, and agree that:

- I have the right to discuss the risks and benefits of all procedures and courses of treatment proposed by my health care provider(s), together with any available alternatives.
- Staten Island Medical & Behavioral P.C. will provide care consistent with the prevailing standards of medical practice but makes no assurances or guarantees as to the results of treatment.
  
- Before prescribing any controlled substance to me, my Staten Island Medical and Behavioral P.C. provider may review information from the Prescription Drug Monitoring Program in my state of residence regarding my prior receipt of controlled substances.

- My Staten Island Medical and Behavioral P.C. is a Xanax and opioid free clinic provider has full right to refuse issuing prescription to these and other controlled substances prescription and I will not force my provider in any way to prescribe controlled substances.
- The laws of the state in which I am located will apply to me as the recipient of telehealth services.
- If there is any change in my health or demographics, I will inform and update Staten Island Medical & Behavioral P.C. and my provider.
- In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room.

4. I consent to, understand, and agree that all my telehealth visits with the psychiatrist will include two services 1) medical management part and 2) counselling part in which psychiatrist will discuss about prognosis, side effects and counsel for the better outcome and will be billed separately to your insurance company.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Section 13 Privacy Notice**

Staten Island Medical and Behavioral P.C. will protect the privacy of my health information and will not use or disclose it except as permitted by law. Staten Island Medical and Behavioral P.C.’s privacy policies are more fully described in the Privacy Notice. By signing this Consent, I acknowledge receipt of the Privacy Notice and consent to Staten Island Medical and Behavioral P.C.’s provider to use and disclosure of my health information in accordance with its terms. I understand that all existing confidentiality protections that apply to in-person treatment apply to telehealth services. By signing this consent electronically, I authorize Staten Island Medical and Behavioral P.C. to disclose information related to treatment, payment, health care operations, and other purposes consistent with the Privacy Notice. I may revoke consent by sending written notice as required by the Privacy Notice. Revocation will be effective upon receipt, except to the extent that Staten Island Medical and Behavioral P.C. has already acted in reliance on my consent.

I will not hold my Staten Island Medical and Behavioral P.C and the provider responsible for a technical error, inadvertent unauthorized disclosure of my information, or loss of information due to technical mistakes or failures.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Patient’s Signatures

\_\_\_\_\_  
Date





I acknowledge, understand, and agree that:

1. It is my responsibility to determine whether Staten Island Medical and Behavioral P. C's services are covered by my insurer. I will pay the cost of any service that is not covered by my health plan for any reason or are covered but applied to a deductible.

Initials: \_\_\_\_\_



2. I will pay at time of service any required co-payments, co-insurance, and deductibles, as well as charges for services not covered by insurance, outstanding balances and delinquent accounts.

Initials: \_\_\_\_\_



3. I assign to Staten Island Medical and Behavioral P.C. all health care benefits to which I am entitled under any insurance policy or benefit plan and authorize payment of benefits directly to Staten Island Medical and Behavioral P.C

Initials: \_\_\_\_\_



4. If I have health care benefits, Staten Island Medical and Behavioral P.C will submit a claim to my insurer and allow 60 days for a response. If my insurer does not respond within 60 days, Staten Island Medical and Behavioral P.C will assume that the visit is not covered and will, to the extent permitted by law, bill me for the visit charges.

Initials: \_\_\_\_\_



5. By providing my credit card information and receiving telehealth services, (I) I authorize Staten Island Medical and Behavioral P.C to charge my credit card for all unpaid amounts that Staten Island Medical and Behavioral P.C or my insurer determines are my responsibility, and (ii) I agree to pay all amounts charged pursuant to this consent and authorization in accordance with the issuing bank cardholder agreement. I agree that Staten Island Medical and Behavioral P.C. may charge my credit card for such amounts at the end of my telehealth visit or at a later date.

6. I will be billed for all unpaid balances deemed by Staten Island Medical and Behavioral P.C. or my insurer to be my responsibility and agree to pay such amounts in full. Staten Island Medical and Behavioral P.C. will charge late fees of \$30 per month on unpaid balances starting 10 days after the first statement, as well as a \$30 fee for returned checks. Delinquent accounts may be turned over to a collection agency at which time I am responsible for a \$70 collections charge and all associated legal fees in addition to the amount owed.

7. Staten Island Medical and Behavioral P.C. reserves the right to deny services if my account is delinquent.

**No show policy:**

If you don't show up on your appointment date and you are unable to reschedule or cancel your appointment 48 hours before your appointment you will be liable to pay a fee of \$75.

**For prescription refill requests** made outside of a scheduled appointment, a fee of \$30.00 will apply. By signing below, you agree to the terms and conditions described in this form.

Print Name: \_\_\_\_\_



Signature: \_\_\_\_\_ Date: \_\_\_\_\_