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: _____

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 ☐ American Indian or Alaska Native
☐ Asian ☐ Black or African American
☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander.

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 (with ages): _____Girls (with ages): _____

How many siblings do you have? Brothers (with ages): _____

Sisters (with 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
☐ Cocaine					
☐ crack cocaine					
☐ heroin					
☐ methamphetamine (meth)					
☐ ecstasy					
☐ hallucinogens					
☐ marijuana (in some states)					
☐ inhalants					
☐ prescription drugs (when sold without a prescription)					
☐ **Opioids** ☐ codeine ☐ fentanyl ☐ hydrocodone ☐ ☐ Hydromorphone ☐ meperidine					
☐ Amphetamines ☐ Dexedrine ☐ Adderall ☐ Ritalin ☐ methadone ☐ morphine ☐ oxycodone ☐ oxymorphone					
☐ Barbiturates Seconal, Nembutal, phenobarbital, and Pentothal. Barbiturates such as Quaaludes, and Rohypnol					
☐ Benzodiazepines					
☐ Cocaine					
☐ Over-The-Counter Drugs ☐ motion sickness drugs (dimenhydrinate) ☐ 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)

☐ Referred by a physician (Name): _____

☐ Referred by a Therapist (Name): _____

☐ A friend (Name of the friend) _____

☐ Other: _____

SECTION 9 **PSYCHIATRIC HISTPRY**

Who was your previous psychiatrist? _____

Tel No. _____ Fax:_____ Email: _____

Address:_____ State: Zip:

What is the reason for your today's visit? _____

_____

_____

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 do you see or hear_____

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

If yes, please explain _____

Did you ever have thought that life is not worth living? ☐ Yes ☐ No

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

If yes, please explain, ☐ Mild fleeing thoughts ☐ Moderate ☐ Severe

☐ have no plan to hurt yourself ☐ I have a plan to hurt myself

Did you ever have thoughts of hurting others? ☐ Yes ☐ No

If yes, please explain: _____

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

Did you ever have fleeting thoughts of hurting others? ☐ Yes ☐ No

Have you ever been to **an EMERGENCY ROOM 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) _____

Have you ever been **Hospitalized for psych reasons?** ☐ Yes ☐ No

If yes, please describe:
Date of visit:_____
Reason of visit_____
For how long were you admitted in 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					
6					
7					
8					

(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 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 or 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. provider will not prescribe opioids to me during a telehealth visit.
• 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.

Print Name: _____

Signature: _____ Date: _____

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

Section 14 **Emergency Cotact**

This information will be extremely important in the event of an accident or medical emergency. Please be sure to sign and date this form.

Name: _____ _____ _____
Last First Middle

Phone (Home): _____ Cell: _____

Home Email Address: _____

1) Primary Emergency Contact:

Name: _____ _____
Last First
Relationship: _____

Phone (Home): _____ Cell: _____ Work:_____

2) Secondary Emergency Contact:

Name: _____ _____
Last First
Relationship: _____

Phone (Home): _____ Cell: _____ Work:_____

Preferred Local Hospital: _____

Comments (include any special medical or personal information you would want an emergency care provider to know- or special contact information.

_____

_____

_____

_____

_____

_____

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 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 non-emergency 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 a fee of $70 can be charged from you.

By signing below, you agree to the terms and conditions described in this form.

Print Name: _____ Signature: _____ _Date: _____