ARMONK CHILD & ADOLESCENT PSYCHIATRY, PLLC

John G. Samanich, M.D., M.S.
One Hunter Avenue, Suite A, Armonk, N.Y. 10504

Tel. 914-730-6377 Fax. 914-600-2242

PATIENT'S INFORMATION

NAME_____
Last First MI PRONOUNS

DATE OF BIRTH_____ BIO GENDER: MALE ____FEMALE____

IDENTIFIES AS: _____

ADDRESS _____

CITY _____STATE_____ ZIP_____

HOME PHONE _____CELL_____

PATIENT'S
EMAIL_____

MEDICATIONS _____

ALLERGIES _____Referred By_____

Preferred Pharmacy_____

EMERGENCY CONTACT _____ _____
Name Relationship

Best Number for Emergency Contact _____

Parent/Payor Information (Must be filled out if the patient is under 18 years of age OR when another party responsible for payment BY SAID PARTY):

Individual Financially Responsible _____

Best Number to reach you at _____Relationship_____

BILLING Email for Invoice/Receipts_____

HOME
PHONE_____WORK_____CELL_____

Signature of Responsible party**X**_____ **Date**_____

ARMONK CHILD & ADOLESCENT PSYCHIATRY, PLLC

PAYMENT POLICY

Payment is expected at the time of your visit. All bills that are 90 days or more past due will be referred to a collection agency. If you are over 18, the collections request will go under YOUR name, not your parents. We firmly adhere to the "No Surprise" Billing Regulations for Behavioral Health Care Providers, therefore please be aware that this is a fee for service practice. PLEASE CHECK WITH THE OFFICE THE CURRENT RATES. THERE IS A SMALL DISCOUNT FOR PATIENTS PAYING CASH/CHECK OR ZELLE. Please check with the office. Family visits are rated with or without the patient's presence at the 1 hour or half hour rate.The frequency of visits is determined by the doctor after careful evaluation of the patient and it depends entirely on the patients' condition, **THE PATIENT MUST BE SEEN A MINIMUM OF ONCE EVERY 3 MONTHS IN ORDER TO REMAIN AN ACTIVE PATIENT OF THE PRACTICE**, which means that you will incur at least 4 visits per year as a minimum. Please make sure to take all this information into account when booking and confirming your appointment, and when signing this paperwork.

Signing this packet is a full acknowledgment of all the information provided here and via email, including all pricing and billing information. An itemized paid receipt will be provided to you via email, for you to submit to your insurance carrier for reimbursement.

Appointments must be cancelled at least 24 hours in advance or there will be a charge in the full amount of the scheduled visit. We do not confirm appointments.
NAME AND SIGNATURE OF PATIENT (if 18yo or older) AND OR GUARDIAN (if Minor):

X_____ Date_____

CREDIT CARD AUTHORIZATION

Our policy is to maintain a current credit card on file so that payments no made at the time of the appointment may still be processed at the time the billing is done. Your credit card will not be billed if you pay by cash, credit card, Zelle or check at the time of service.

I agree to pay by cash, credit card or check at the time of service and I acknowledge my credit card number on file will be charge in the event that non payment for a visit or if my account becomes past due, unless other arrangements have been made. Payment is due at the time of service.

Type of Credit Card (circle one) MasterCard Visa Amex Discover

Name as it appears on card_____

Billing Address _____Security code_____

Credit Card Number _____

Expiration Date_____Signature of cardholder **X**_____

ARMONK CHILD & ADOLESCENT PSYCHIATRY, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF BILLING POLICIES AND PRACTICES

I acknowledge that I have read, understand and agree with the policies of Armonk Child and Adolescent Psychiatry, PLLC

Patient or Guardian_____

Print Name

Signature **X**_____Date_____

Signature of person responsible for payment If different from patient or

guardian **X**_____Date_____

INSURANCE INFORMATION IS NEEDED AT TIMES FOR AUTHORIZING TESTING AND OR MEDICATIONS. PLEASE COMPLETE THE SECTION BELOW FOR OUR RECORDS OR PROVIDE A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD. THANK YOU.

Carrier_____ID#_____Group#_____

Insurance Phone #_____

IF PATIENT IS NOT THE INSURED PLEASE COMPLETE

Name of insured_____

Date of Birth_____Relationship to patient_____

PATIENT TELEHEALTH APPOITNMENTS RELEASE FORM

I,_____ request to have video/phone Session(s) flexibility with Dr John Samanich at ACAP. I know my privacy will be assured at the office of Armonk Child and Adolescent Psychiatry, PC, although the security of the connection can not be guaranteed. I accept the risks inherent in this form of communication.

*Patients eligible for video calls/phone sessions are 17yo and older, at the doctor's discretion. Thank you.

This authorization will be valid from the date of signature, until revoked in writing.

X_____ _____

Signature of Patient Date

X_____ _____

Signature of Parent or Guardian Date

ARMONK CHILD & ADOLESCENT PSYCHIATRY, PLLC

AUTHORIZATION

Authorization for release of medical, psychiatric and billing records (Protected Health Information)

The information covered by this authorization includes all medical, psychiatric and billing information pertaining to your care at Armonk Child & Adolescent Psychiatry and Dr. John Samanich. The information may be used and/or disclosed by the physicians and staff pertaining to your care.

Please list the **names and phone numbers** of any private **physicians, therapists and/ or family members** that you **wish to have authorization** to speak with Dr. Samanich. Patients over 18 years of age must give permission for their provider to speak to their parents.

_____

_____

If you wish to **restrict** your private medical information from disclosure to an individual or entity (including your insurance company) – please list the names below.

_____

This authorization is effective through life unless revoked or terminated by the patient or the patient's legal representative. You may revoke or terminate this authorization by submitting a written revocation to the office.

Potential for re-disclosure of information that is disclosed under this authorization may be that it is disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

Name of Patient _____Date of Birth_____

Signature of Patient **X**_____Date_____

Patient Consent for Treatment and Use and Disclosure of Protected Health Information

I hereby give my consent for Armonk Child and Adolescent Psychiatry, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO) as specifically outlined on my authorization.
The Notice of Privacy Practices provided by Armonk Integrated Psychiatry, PC describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Armonk Integrated Psychiatry, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Joy Samanich, HIPAA Compliance Officer** for Armonk Child and Adolescent Psychiatry, PLLC, One Hunter Avenue, Armonk, NY 10504. With this consent, Armonk Child and Adolescent Psychiatry, PLLC may call my home or other alternative location** and leave a message on voicemail 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 test results, among others.

With this consent, Armonk Child and Adolescent Psychiatry, PLLC 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. With this consent, Armonk Child and Adolescent Psychiatry, PLLC may email to my email address on file or alternative email** any items that assist the practice in carrying out TPO such as appointment reminders and patient statements. I have the right to request that Armonk Child and Adolescent Psychiatry, PLLC restrict how it uses or discloses my PHI in order to carry out TPO. 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 allow Armonk Child and Adolescent Psychiatry, PLLC to provide treatment for myself or my child (which ever applicable). I may revoke my consent in writing except for treatment already provided and 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, Armonk Child and Adolescent Psychiatry**,** PLLC may decline to provide treatment to me/or my child.

X_____ _____

Signature of Patient Print Patient's Name

_____ _____

Print Name of Patient or Legal Guardian, if applicable Date

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PATIENT-PROVIDER ELECTRONIC COMMUNICATION AGREEMENT

E-mail, Phone calls and Text messaging offer an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls, but please be aware that there are important differences. All electronic communications carry with it certain risks. Risks of communicating via email include, but are not limited to:

- Email may be seen by unintended viewers if addressed incorrectly.

- Email may be intercepted by hackers and redistributed. Someone posing as you could access your information. Email can be used to spread computer viruses. There is a risk that emails may not be received by either party in a timely manner, as it may be caught by junk/spam filters, or the doctor may be out of the office or on vacation.

- Emails are discoverable in litigation and may be used as evidence in court. Emails can be circulated and stored by unintended recipients.

- Statements made via email may be misunderstood thus creating miscommunication and/or negatively affecting treatment.
  Nonetheless, we believe that the ease of communication which these methods afford is a benefit to patient care. Below are our guidelines for contacting us via e-mail or text.
  • E-mail or texting is never, ever appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Room of the nearest hospital, for emergencies.
  •E-mails should not be used if you are experiencing any desire to harm yourself or if you are experiencing a severe medication reaction.
  •E-mail is NOT a substitute for seeing your clinician. If you think that you might need to be seen, please book an appointment.
  •Appropriate uses of e-mail include prescription refill requests, referral and appointment scheduling requests and billing questions.
  •E-mails or texts should not be used to communicate sensitive medical information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability or substance abuse.
  •E-mail is not confidential. Emails may be forwarded to office staff to handle routine, non clinical matters.

- Do not use your work computer for emails .You should know that if sending e-mails from work, your employer has a legal right to read your e-mail if the email has gone through their system. E-mails will become part of the permanent medical record and, as such, they will be released along with the rest of the record upon your authorization, or when we are otherwise legally required to do so.

- You must let your provider know immediately if your email changes.
  Please note that our computers and wifi are password protected and encrypted. We do not
  access email from public wifi spots and emails are treated with the same HIPPA privacy rules.
  Either one of us can revoke permission to use the e-mail system at any time and must be done by written online communications or in writing to my office.

x____(initials please) **I DO want to communicate with my doctor electronically** by either email, text or phone. I have read the above information and understand the limitations of security on information transmitted.

Patient Name_____

Patient Signature **X**_____Date_____

E-mail Address_____
(if applicable)