NEW PATIENT REGISTRATION FORM

8120 Woodmont Avenue, St. 205
Bethesda, MD 20814
Tel # (301) 892-6780

Name:

Date of Birth:

Address:

SSN (last 4 digits):

Phone (M): (_____) _____ - _____

Phone (H): (_____) _____ - _____

Email:

Please advise our office of any changes in your contact information. Email and/or text message to be used for appointment reminders.

Primary Care Physician:

Phone: (_____) _____ - _____

Other physicians (OB/Gyn, neurologist etc.):

Phone: (_____) _____ - _____

Therapist:

Phone: (_____) _____ - _____

Pharmacy:

Phone: (_____) _____ - _____

Current Medications:

Allergies:

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Previous psychiatric medications:

Emergency Contact Name:

Relationship:

Emergency Contact Number: (_____) _____ - _____

What brings you to see us today?

How did you hear about Dr. Rosner?

I voluntarily consent to treatment and understand that I have the right to make informed decisions regarding my care.

I understand that I am responsible for payment for psychiatric services and/or appointments made and I hereby consent to payment automatically withdrawn from my (or my responsible parties) account on the morning of the appointment date. I am responsible for the full cost of any appointments unless I give notice of cancellation at least two (2) full business days prior to appointment.

I acknowledge that I have received or declined the Notice of Privacy Practices. I understand that this Notice is available for me to keep.

Patient or responsible party signature **Date**

Printed Name

INITIAL CONSULTATION – CONSENT TO ENGAGE IN TREATMENT

All initial appointments at Elizabeth Rosner, Psychiatrist, M.D. ("Provider") are consultation appointments. Providers will perform a full evaluation and give feedback regarding the evaluation and any recommended treatment plan. The consultation is designed so that the provider and patient can determine by the end of the initial appointment if they would like to continue working together. If so, the Provider will become the patient's treating psychiatrist. If at any point during treatment, the Provider or the patient determines that the patient would be better served by receiving treatment from a different provider, this will be discussed, and referrals will be provided to the patient.

CONFIDENTIALITY

All information shared with provider will be kept completely confidential as mandated by HIPAA. Provider may share certain information to a third party only with the express written agreement and consent of the patient AND if the Provider deems that doing so is in line with the patient's treatment plan. There are some situations in which Provider may be legally required take action that could include revealing some information about the patient's treatment. Examples of such situations include imminent risk/threat of self-harm (patient), imminent risk/threat of harm to others, and child or elder abuse. Please refer to Provider's Privacy Practices document for full details on all privacy practices. A copy of privacy practices is given to all new patients and is also available upon request.

BILLING/PAYMENTS

Payment is due in full on the morning of the appointment date and payments will be charged to patient's or responsible parties provided credit card. Dr. Rosner uses a secure and HIPPA compliant payment service called "IVY PAY". Credit cards are required to be kept on file as is standard practice. All payments will be charged an additional 3% processing fee. Elizabeth Rosner, Psychiatrist, M.D. is an "out-of-network" provider and is unable to directly file claims with insurance as a form of payment. Patients with health insurance will need to pay out-of-pocket on the morning of the scheduled appointment and are encouraged to submit claims to their insurance and utilize any out-of-network benefits. All patients will be provided with a specialized invoice (receipt) after services rendered that contains information that may be necessary to submit claims for out-of-network reimbursement. All dealings with insurance companies will be addressed by the patient. Dr. Elizabeth Rosner, M.D. is not responsible for issues related to insurance claims. Dr. Rosner encourages all patients to enquire with their insurance companies (prior to engaging in treatment) should they desire to use insurance. Codes will be provided upon request.

APPOINTMENTS/CANCELLATIONS

Patients are financially responsible for all services scheduled with Elizabeth Rosner, Psychiatrist, M.D. If a patient would like to cancel an appointment, notice must be given within 1 full business day (24 hours excluding weekends and holidays) prior to the appointment. Any cancellations received after this time will be charged for the full session. Patients arriving late to appointments will be subject to charge for the full session. Patients who arrive with less than 10 minutes remaining in the appointment will not be seen. The patient will be charged for the full session and a new appointment will need to be scheduled.

Policies and Procedures

MEDICATION REFILLS: When calling about a refill, please leave your name, date of birth and your phone number, along with the medications requested, their dosages and the phone number of your pharmacy. If accepted by the provider, please allow 2-3 business days for medications to be refilled.

CONTACT INFORMATION

Contact Dr. Rosner at 301-892-6780 and your call will be returned at her earliest availability.

In the event of a medical or psychiatric emergency, please call 911 or go to your nearest emergency room.

I have read and understood the policies as stated above. I have had the opportunity to discuss my questions and concerns. I agree to comply with the office policies and procedures as noted.

Patient or responsible party signature: **Date:**

Print Name

Credit Card Authorization Form:

It is standard policy to keep a credit card information on file for patients.
I, _____, herby authorize Elizabeth Rosner, Psychiatrist, M.D to keep this form and my signature on file and charge my credit card the full amount on the morning of my scheduled appointment and/or for any of the following services:

1. Initial evaluation
2. Follow-up appointments for medication management, psychotherapy or other related services.
3. Appointments that I do not cancel prior to 1 full business day of the scheduled appointment
4. Additional and/or future services that I verbally approve
5. Additional time spent on letters (i.e. accommodation letters, forms), or other requests made by me that require time spent outside of the scheduled appointment
6. Appointments that go over the 60 or 30 minute appointment time will be charged by cost per minute x additional minutes

Cardholder Name:

(name as it appears on credit card)

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: Expiration Date:

Credit Card Billing Address: CVV Code:

I agree not to dispute charges for any of the terms outlined above.

I understand the terms of this form and agree that it is valid for five (5) years unless treatment is terminated or I cancel this authorization through written communication with Elizabeth Rosner, Psychiatrist, M.D

Patient or responsible party signature **Date**

Printed Name

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Medical Information Release Form:

Patient name:

DOB:

I hereby consent to Dr. Elizabeth Rosner, Psychiatrist, M.D. obtaining and/or disclosing healthcare information to/from the healthcare providers listed below. I authorize Elizabeth Rosner, Psychiatrist, M.D to do the following with my protected health information:

☐ Disclose and/or obtain protected healthcare information to/from individuals/entities listed below

☐ Provide a complete copy of my healthcare records to those individuals/entities listed below

☐ Provide only part of my health care records, limited to the following information, to those individuals/entities listed below:

Name of Person/Entity:

Address: Phone:

Name of Person/Entity:

Address: Phone:

Name of Person/Entity:

Address: Phone:

I understand that the medical information released may contain information related to HIV/AIDS status, sexually transmitted diseases, mental health and drug or alcohol abuse.

Patient or responsible party signature **Date**

Printed Name

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Your Provider's Responsibilities

Your protected health information includes records that your provider creates and obtains when at the onset and duration of treatment with your provider. Examples include but are not limited to: a record of your symptoms, examination, test results, diagnoses and treatments. It also includes payment information related to your care. The law requires your provider to keep your health information private in accordance with this Notice of Privacy Practices. Your provider is also required to provide you with a copy of this document, which contains your providers privacy practices, legal responsibilities, and your rights concerning your health information.

Permitted Uses and Disclosures

Under federal law, your provider may use and disclose your health information without authorization for treatment, payment or health care operations. Examples of such potential uses or disclosures are provided below:

Treatment

Your health information may be used by or disclosed to any physicians or other health care providers involved with the medical services being provided to you. Your provider may also use your health information to manage or coordinate your treatment.

Payment

Your health information may be used or disclosed in order to collect payment for the medical services provided to you.

Health Care Operations

Your health information may be used or disclosed as part of internal health care operations, such as quality of care audits, training programs, accreditation, certification, licensing or credentialing activities.

While the following disclosures can be made without your consent or authorization, your provider will make her best effort to inform you when a disclosure is being made or there is an intention to do so.

Other Uses and Disclosures without Authorization

Abuse, Neglect, or Domestic Violence

As required by law, your provider may disclose your health information to report suspected abuse, neglect, or domestic violence.

Judicial and Administrative Proceedings

Your provider may disclose your health information in the course of a judicial or administrative proceeding, in response to a subpoena or other orders required by law.

Notification

Your provider may use or disclose your health information to notify a family member or other person identified by you who is involved in for your care about your location, about your general condition, or about your death. Your provider will provide you an opportunity to object before disclosing any such information.

Public Safety

Your provider may disclose your health information for public health purposes such as a serious and imminent threat to the health or safety of a person or the public.

Required by Law

Your provider may be required by federal, state, or local law to disclose your health information.

Third party

Your provider may disclose your health information to third parties with whom we contract to perform services on our behalf. Your provider will have an agreement with them to safeguard your information. Your provider will not disclose your health information for any reasons, except those described in this Notice of Privacy Practices, unless you provide written authorization to do so. Your provider may request an authorization to use or disclose your health information for any purpose, but you are not required to give authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Rights

You have the following rights with respect to your protected health information:

Requesting Restrictions
You have the right to request a restriction on limiting our use and disclosure of your health information. Your provider is not required to agree to your request however, if agreed your provider will abide by your request except as required by law, in emergencies or when the information is necessary to treat you. To request a restriction, it must: 1) be in writing 2) describe the information that you want restricted 3) state if the restriction is limited to use or disclosure and 4) state to whom the restriction applies.

Confidential Communications
You have the right to request that we communicate with you about your health information in a particular way or at a certain location, to maintain your confidentiality. To request confidential communication, it must: 1) be in writing and 2) specify how or where you wish to be contacted. We will accommodate all reasonable requests. You do not have to give a reason for your request.

Inspect and Copy
You have the right to inspect and obtain a copy of your health information. To request to inspect or obtain a copy of your health records, it must be in writing. Your provider may charge a fee for record retrieval, copying costs, mailing and other supplies.

Amendment of Health
You have the right to request amendment of your health information, if you believe that it is incorrect or incomplete. To request an amendment, it must: 1) be in writing and 2) include a reason to support your amendment request. Your request may be denied if it was not created by provider, if the provider believes that the information is complete and accurate or if the information is not part of the medical information that you would be permitted to inspect or copy.

Accounting of Disclosure:
Under federal law, you have the right to request a list of the disclosures that the provider has made of your health information over the previous six years. This right applies to disclosures other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. Your first request within a 12-month period is free, but charges may apply for additional lists within the same 12-month period. To request an accounting of disclosure, it must be in writing.

Paper Copy of This Notice
You have the right to keep a paper copy of this Notice of Privacy Practices.

File a Complaint
If you believe that your privacy rights have been violated, you may file a complaint directly with your provider in writing. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

This Notice of Privacy Practices and its terms may be revised as permitted or required by law. Your provider has the right to make the revised notices effective for information that your provider has

about you, as well as information obtained in the future. The updated Notice of Privacy Practices will be provided to you in paper copy.

I acknowledge that I have received the Notice of Privacy Practices. I understand that this Notice is available for me to keep.

Patient or responsible party signature **Date**

Printed Name