

PATIENT INFORMATION

Date _____ Referred by _____

Last Name _____ First Name _____ MI _____

Patient's Address _____
(Street) (City). (State). (Zip)

Home # _____ Cell # _____ Work # _____

Current Physician _____ Physician Number _____

Previous Psychiatrist/Nurse Practitioner _____

(Address and Phone Number)

For Minor Patient

Mother's Last Name _____ First Name _____ DOB _____

Father's Last Name _____ First Name _____ DOB _____

Who does the child live with _____ Address _____

Legal Guardian _____ Guardian's Address _____
(if different then a parent)

(Please provide a copy of the court possession order)

Patient Name _____ DOB _____

Policy Holder's Name _____ DOB _____

Policy Holder's Employer _____ Insurance Company _____ Policy Number _____

Group Number _____ Benefits # _____ Pre-Cert # _____

Gender: F ___ M ___ SSN _____ TDL _____

Relationship to insured: Self ___ Spouse ___ Child ___ Other ___

___ I have no insurance coverage under any other group health plan (please initial)

___ I have secondary coverage as follows:

Policy Holder's Name _____ DOB _____

Policy Holder's Insurance Company _____ Policy # _____ Group# _____

Gender:F ___ M ___ SSN _____ Relationship to Insured: Self ___ Spouse ___ Child ___ Other ___

Signature of Patient or Patient's Guardian

Date

Print Name of Patient or Patient's Guardian

Date

MIDTOWN PSYCHIATRY AND TMS CENTER, PLLC
DANIELA M. WHITE, MD
www.danielawhite-md.com

Authorization for Release of Medical Information from Medical Records

Patient Name _____ DOB _____

Date Requested _____ (valid for 365 days unless otherwise specified)

I hereby authorize Daniela M. White, MD or MPTC, PLLC to release or obtain (please circle one or both)

information to or from (please circle one or both) _____
(Name of Person/ Physician)

(Address or Phone Number or Both)

Information from Medical Record should include

Complete/Part of Medical Record _____	Medical History and Physical Exam _____
Psychological Report _____	Psychitric Assessment. _____
Medical History and Physical Exam _____	Laboratory Reports. _____
Verbal Communication Only _____	Other _____

I understand and agree that the information I am authorizing to release may include mental health information, HIV test results, diagnosis, drug tests results, treatment and related information.

I further understand that I may cancel this authorization at any time by notifying the office in writing, except for the action that has been taken in reliance on it. Unless earlier revocation, this authorization automatically expire in 365 days after date of request unless another date, event or condition specified.

To the Party Receiving this Information:

This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains.

I release and agree to hold Dr. Daniela M. White, MD or MPTC, PLLC employees and representatives harmless from all liability associated with the release of my patient confidential information. I understand that Dr. White or MPTC, PLLC cannot be responsible for the use of redisclosure by a third party.

Patient/Guardian Signature.

Witness

Print Name.

Print Name

Date

Date

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MPTC FINANCIAL POLICY

MPTC is committed to providing you with quality care. Your clear understanding of the financial policy is important to our professional relationship. Please ask if you have questions about it.

To assist us in establishing your financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information
- Bring your insurance card at each visit.
- Inform us 2 days in advance of your appointment if there have been any changes in your insurance coverage.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day your services are rendered.
- Authorize release of information necessary for insurance filing and pre-certification (sign below)

UNACCOMPANIED MINORS: Minor must have authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductible are expected at the time of service.

REGARDING DIVORCE: MPTC, PLLC or Dr. White do not get involved in disputes between divorced parents regarding financial responsibility for the child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care provided to your child, regardless of weather a divorce decree or other arrangement places that obligation on your former spouse.

TELE-PSYCHIATRY: In order to prevent interruption of care in case of your travel or temporarily living away for school or work, this office provides Skype sessions. Skype sessions are highly encrypted to protect for the privacy of the conversations. By signing below, you agree to insure the privacy of the conversation at your location during the Skype session. Payments are due at the time of the service through credit card or a check mailed in advance.

REGARDING INSURANCE: Full payment is required at the time of service. We will supply a copy of your statement so you can file for reimbursement from your insurance provider if we are an out of network provider.

Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-insurance, coordination of benefits, pre-existing conditions. You are responsible for the timely payment of your account.

Dr. Daniela White is not a Medicare provider and you can not file Medicare for the charges incurred. Initial that you understand this statement.....

- I have read and understand that I am personally responsible for payment on this account
- I authorize payment directly to Dr. White or MPTC, PLLC. Any changes in this authorization must be received in writing within 30 days of the effective date.
- I understand that this practice has a no show charge equal to a full fee. I am responsible for paying the fee if I do not cancel an appointment with 24 hours notice
- In the event my insurance company deems a service " non-covered" I understand that I am personally responsible for payment
- I agree to release of any and all medical information, and financial information necessary to process this and future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within 30 days of effective date
- I agree to pay the fee associated with writing letters, filling disability and FMLA papers, and release of a copy of my records.
- I agree to pay a fee of \$ 15 for the schedule 2 prescriptions that need to be rewritten (if I miss the appointment, or lost the original prescriptions).

Guarantor Signature _____ Date _____

Print Name _____ Relationship to Patient _____

PATIENT NAME _____ Date of Birth _____