Scott A. Fleischer, M.D., P.C., & Associates
455 Pennsylvania Avenue • Suite 105 • Fort Washington, Pennsylvania 19034 Phone:
(215) 793-4546 • Fax: (215) 793-9007

Dear Patient,

Welcome to Dr. Fleischer's office. Enclosed you will find the necessary forms that need to be completed prior to your first appointment with our office. Please complete any highlighted areas and return them to our office.

- ☐ **PATIENT REGISTRATION**
- ☐ **FINANCIAL POLICY AGREEMENT**
- ☐ **RELEASE OF INFORMATION**
- ☐ **INFORMED CONSENT FOR TREATMENT / AUTHORIZATION TO PAY**
- ☐ **MAGELLAN HEALTH SERVICES** ***(Relevant because many insurance companies use Magellan to administer their Behavioral Health Benefits. No signature required)***
- ☐ **PROVIDER COMMUNICATION RELEASE**
- ☐ **MEDICAL HISTORY**
- ☐ **HIPAA NOTICE OF PRIVACY PRACTICES** ***(<u>For your records.</u> No signature required)***

Please bring the completed forms, insurance card, and any co-payments with you when you come for your appointment. Please arrive 15 minutes prior to your appointment time.

If you need to reschedule or cancel your appointment, kindly give 2 business days' notice to avoid a charge.

We look forward to meeting with you.

Thank you,

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PATIENT REGISTRATION FORM

PLEASE COMPLETE ALL LINES

Patient Name _____ ☐M ☐F ☐T

Date of Birth _____ **Age** _____ **Social Security #** _____

Marital Status ☐Single ☐ Married ☐Widowed ☐ Divorced **Email Address** _____

Patient's Home Address

_____

City, State, Zip code

_____

Patient's Home Phone _____ **Patient's Cell phone** _____

☐ **I give you permission to call my home and/or my cellular phone for appointment reminders, medical issues and billing.**

Preferred Contact Method ☐ Home phone ☐ Cell phone

Is it OK to leave a detailed message on answering machine ☐YES ☐NO **or with spouse / adult relative?** ☐YES ☐NO

Is it OK to send letter or fax (such as an appointment reminder or lab results)? ☐YES ☐NO

How did you hear about us? ☐Friend / Colleague ☐Internet Search ☐Physician Referral

_____

Emergency Contact Name _____ **Phone number** _____

Insurance **Subscriber's Name** _____ **Subscriber's Employer** _____

Subscriber's Date of Birth _____/_____/_____ **Relationship to Patient** _____

Pharmacy Name _____ **Pharmacy Phone Number** _____

Pharmacy Address

_____

Receipt of HIPAA Notice of Privacy Practices Written Acknowledgement

I have received and had an opportunity to read the Office's HIPAA Notice of Privacy Practices. I am informed that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended notice.

___ YES ___NO

Government Statistical Information (Optional)

Language Preference: ☐English ☐Spanish ☐Other _____

Race ☐White ☐American Indian / Alaskan Native ☐Asian or Asian American ☐Black / African American ☐Hawaiian or Pacific Islander ☐Other _____

Ethnicity ☐Hispanic or Latino ☐ **NOT** Hispanic or Latino

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FINANCIAL POLICY AGREEMENT

Patient (print) _____ Date of Birth _____

CANCELLATION / MISSED APPOINTMENT FEE

Any missed appointment or canceled appointment with less than 48 HOURS NOTICE may be subject to a $75.00 cancellation fee. Our office utilizes an auto-call service that will issue a reminder 72 hours or more prior to your appointment, but it is your responsibility to remember your appointment. Unlike other types of doctor appointments, Dr. Fleischer and his associates set aside a block of time just for your appointment. You can cancel your appointment up until 48 hours prior to your appointment by calling the main office at 215-793-4546 and press option 6 to reach the appointment hotline. The time of your call will be marked by our system. If there is an emergency and you cannot make your appointment and cannot cancel with 48 hours' notice, if you call, you may be given the option of participating in a telephone session with your clinician ($75.00, in lieu of the cancellation fee) that cannot be billed to the insurance company and **must** be paid by credit card prior to the phone session. Please help us serve you better by keeping scheduled appointments.

PRESCRIPTION REFILL FEE

Our clinicians are very happy to write necessary prescriptions for our patients at the time of their appointment that will carry them through until their next appointment. Patients are encouraged to bring a list of medications needed to their appointment. However, if you require a prescription before your next appointment or if you forgot to request a refill at the time of your appointment, please note that you may be charged a fee of $30.00 for this refill. You are invited to make a short appointment to have your prescriptions renewed if you do not wish to pay the $30.00 prescription refill fee. You can leave a refill request or make a short appointment by calling the main office at 215-793-4546 and press option 7 to reach the prescription hotline or press 6 to schedule an appointment.

BOUNCED OR RETURNED CHECKS

There will be a $25.00 fee assessed for bounced or returned checks.

OTHER FEES / FEES NOT COVERED BY INSURANCE CARRIER

You may be charged a nominal fee for record copying and mailing or preparation of reports. Therapy over the phone will be assessed a fee that is due prior to the session, and is not covered by most insurance carriers. All patients are responsible for any copays, deductibles, co-insurance, out of pocket, or non-covered expenses not covered by insurance.

I have read, fully understand and agree with the **financial policy and office policies** of this office and agree to abide by its guidelines.

Patient or Guardian signature _____ **Date** _____

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Release of Information Form

If you wish to have a family member, power of attorney, etc. discuss any aspect of your medical care with our providers and staff, please sign below and indicate to whom we may speak.

☐**Check this box if you decline authorizing permission to others.**

I give permission to Scott A. Fleischer, M.D., P.C. & Associates to discuss my medical care with _____, who is my _____.

Print name of individual ***Relationship***

_____ _____
(Signature) **(Date)**

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INFORMED CONSENT FOR TREATMENT / AUTHORIZATION TO PAY

Patient's Name: _____ **Date of Birth** _____
(As it appears on insurance card)

I agree and consent to participate in behavioral health care services offered and provided at Scott A. Fleischer, M.D., P.C. & Associates. I understand that I am consenting and agreeing only to those services that the providers are qualified to perform within the scope of the provider's license, certification, and training.

I agree to comply with the Treatment Plan determined by my provider by:

- Adhering to the schedule of outpatient visits
- Adhering to medication treatment regimen and diagnostic testing as prescribed (unless problems/reactions arise and changes need to occur)

I understand that my compliance with the Treatment Plan is critical to feeling better. I acknowledge that non-compliance with my Treatment Plan could result in being discharged from the practice.

I agree, in order for you to service my account or to collect any amounts that I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Contact may include using pre-recorded / artificial voice messages and / or use of an automatic dialing device, as applicable.

_____
_____
Signature of patient or responsible party **Date**

AUTHORIZATION TO PAY / AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I request that payment of authorized Medicare and / or Insurance benefits be paid directly to Scott A. Fleischer, M.D., P.C. I permit a copy of this authorization to be used in place of the original. I authorize the release to the Social Security Administration, Centers for Medicare and Medicaid Services or its intermediaries, or to my medical insurance carriers any information regarding this or related claims. **I understand that I am responsible for any copays, deductibles, co-insurance amounts, and non-covered services.**

_____
_____
Signature of patient or responsible party **Date**

FOR MEDICARE / SECONDARY INSURANCE POLICY HOLDERS ONLY:

If you have a "Medigap" Policy to which your Medicare carrier crosses over, we need a separate signature. I request "Medigap" benefits be paid on my behalf for services furnished. I authorize Scott A. Fleischer, M.D., P.C. & Associates to release to my "Medigap" carrier information needed to determine my benefits.

_____
_____
Signature of patient as it appears on insurance card **Date**

Relationship to Patient (if applicable): _____

MAGELLAN HEALTH
MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand, and free of charge.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Magellan, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- If asked, Magellan will act on the member's behalf as an advocate.*
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.
- Receive information about Magellan's staff qualifications and any organization Magellan has contracted with to provide services.*
- Decline participation or withdraw from programs and services.*
- Know which staff members are responsible for managing their services and from whom to request a change in services.*

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Let Magellan and their provider know if they decide to withdraw from the program.*

* This standard is required for our *Condition Care Management* (CCM) products.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Signature Date

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PROVIDER COMMUNICATION RELEASE

Patient Information

Patient Name	**Date of Birth**

Primary Care Provider Information _____ **I do not have a Primary Care Provider**

Medical Provider Name	**Phone Number**
Address	**Fax Number**

Psychologist or Therapist Information _____ **I do not have a therapist or psychologist**

Name	**Phone Number**
Address	**Fax Number**

Patient Rights

- You can end this authorization (permission to use or disclose information) at any time by contacting this office.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous consent.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information that is disclosed as a result of this authorization form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization:

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall be valid as long as I am a patient with the practice, unless another date is specified. I have read and understand the above information and give my authorization.

Please check one:

I agree to release:

_____ any applicable mental health/substance abuse information to my medical provider or therapist

_____ only medication information to my medical provider or therapist

_____ I do not give my authorization to release any information to any provider.

Patient Signature: _____ **Date**: _____

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MEDICAL HISTORY

Please complete all applicable lines

Patient Name _____ **DOB** _____ **Date** _____
Age _____ **Referring Doctor** _____ **Tel.#** _____
Pharmacy ___ **Tel.#** _____

Chief Complaint: __agitated __ depressed __wandering __anxious__other_____

[For clinician use only]
1. Location
2.Severity
3.Timing
4.Mod. Factors
5.Quality
6.Duration
7.Context
8.Assoc. Signs & Symptoms

History of The Present Illness

Please check all of the symptoms below that apply

___Mood: depressed/euphoric/diurnal variation/mixed mood
___Sleep: initial/middle insomnia early morn. awakening/hypersomnia
___Interest level: __ increased__decreased
___Energy level: __ increased__decreased
___Concentration: __ decreased
___Guilty feeling
___Hopelessness /Worthlessness/Suicidal Ideation/Plan_____
___Appetite: __ increased __ decreased __wt. Δ (___lbs.)/time_____
___Anxiety: __ calling out __ Panic attacks
___Heart races/shortness of breath/sweating/want to run away/nausea
___Feel euphoric
___Racing Thoughts __Shopping Sprees __Talk fast ___Life of the party
___Obsessive thoughts __ compulsive rituals_____
___Sexual problems_____
___Irritability__In pain:cause_____
___Paranoid Delusions: elaborate/memory type_____
___Hallucinations: auditory/visual _____
___Agitation/ Time of Day_____Trigger_____
___Memory impairment / Impaired Language /_____
___Other:_____

_____

_____

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS (name, dosage, frequency):

1._____ 4._____ 7._____ 10._____ 13._____
_____
2._____ 5._____ 8._____ 11._____ 14._____
3._____ 6._____ 9._____ 12._____ 15 _____

Allergies _____

Please complete all applicable lines

Patient Name_____

PAST /FAMILY AND SOCIAL HISTORY
PAST PSYCHIATRIC HISTORY (include dates & reason)
Treatment & Hospital _____

_____

_____

Antidepressants_____ Dementia_____ Antipsychotics_ Antianxiety/Sleep Agents _____
Antimanic/Mood Stabilizers _____ ADHD Drugs _____

Family Psychiatric History_____

_____

_____

_____

_____

_____

_____

Social History
Key Life Events that Impacted your Life _____

_____

_____

_____

_____

Education/ Grade completed _____
Marriage/Dating _____

_____

_____

Work_____

_____

_____

Substance Use: Alcohol / Tobacco / Caffeine / Marijuana / Cocaine/_____

_____

_____

Past Medical History
Past Medical History _____
Past Surgical History _____

MEDICAL HISTORY:
Current Medical Diagnosis _____
Primary Care Doctor_____**tel.** #_____

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HIPAA NOTICE OF PRIVACY PRACTICES

Scott A. Fleischer, M.D., P.C. is required by Federal law to maintain the privacy of your health information. This Notice, Effective April 14, 2013, describes the privacy practices utilized by this office. It defines how your health information may be used and disclosed, and how you can have access to this information. This office reserves the right to change our privacy practices as the law permits. This Notice will be amended accordingly. This practice takes all reasonable measures to prevent unauthorized access to the Protected Health Information (PHI) of our patients. PHI refers to any information that can be used to identify a patient in our practice. We will not disclose your PHI without your consent and/or authorization, except as allowed by law and described in this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI):

A. Release of patient PHI is limited for any given purpose to the minimum amount needed to disclose. Without patient, or guardian, authorization, a patient's PHI may be disclosed via mail, electronically, by telephone or facsimile machine under the following circumstances:

1. *For Treatment:* Which is described as the provision, coordination or management of health care and related services; this includes consultation with the following: another health care provider; pharmacist; home health care agency or worker; nursing home staff; case managers; and / or clinical laboratories.
2. *For Payment of Services Provided:* This includes disclosure to insurance companies or other providers of reimbursement and/or collection agencies.
3. For Health Care Operations: This is described as activities needed to keep our practice operable. This includes disclosure to our office staff in preparation of medical records, outside health or management reviewers and individuals performing similar duties.
4. *Business Associates*: In support of our operations, we may contract with business associations, such as our answering service, who assist us in providing services. We may disclose PHI for contracted tasks to be performed.
5. *For Contacting You*: Appointment reminders to patients/clients at the residence telephone number/answering machine, or cellular phone number/voice mail provided. Telephone numbers for places of employment would only be contacted with direct authorization from patient. Contact may include using pre-recorded / artificial voice messages and / or use of an automatic dialing device, as applicable.
6. *Health Oversight and Public Health Activities*: To prevent or control disease, injury or disability, as required or allowed by law.
7. *In Case of Emergency/To Avert Serious Threat to Health or Safety:* Using our best judgment, we may use or disclose PHI necessary to notify or assist in notifying another healthcare provider, family member, or personal representative in the case of emergency, or to avert a serious threat to the health and safety of you or others.
8. *As Required or Allowed by Law*: We may disclose your health information in other circumstances, as required or allowed by applicable regulation or law.
9. *Worker's Compensation*: We may disclose treatment information if you file a workers' compensation claim.
10. *Coroner's and Funeral Directors*: We may disclose information about you to a coroner if the information is relevant to the coroner's duties such as contacting a decedent.

B. Release of patient information is limited for any given purpose to the minimum amount needed to disclose. With patient or guardian authorization, a patient's confidential information may be disclosed via mail, electronically, by telephone, facsimile machine, or in person under the following circumstances:

A patient may request confidential information contained in their record be disclosed to a family member, other relative, close personal friend, or any other person identified as a personal representative. The information shared will be directly relevant to the individual's involvement with your care or payment for services. For example, an authorized individual may be allowed to pick-up a prescription or make a payment on your behalf.

1. A patient may request copies of their record be forwarded to an attorney, insurance company or government agency upon signing a Release of Information. The requested information will be forwarded after payment of cost-based fees.
2. In addition to maintaining patient PHI in accordance with Federal laws such as HIPAA (Health Insurance Portability and Accountability Act) and HITECH, (The Health Information Technology for Economic and Clinical Health) this practice, and any qualifying third-party business associates, strictly abide by the requirements under the Genetic Information Nondiscrimination Act (GINA). Title I of GINA addresses the use of genetic information

in health insurance. Title II of the Act prohibits the use of genetic information for underwriting purposes and imposes strict confidentiality requirements.

3. This practice will not share or disclose patient PHI for marketing or fundraising purposes without obtaining the patient's authorization.

You may revoke an authorization at any time, in writing. Disclosure made prior to the receipt of documentation revoking an authorization cannot be considered a violation.

II. A patient, or guardian, has the right to request in writing, a limitation or restriction on the use or disclosure of confidential information, which may be accepted or denied.

III. <u>ACCOUNTING OF DISCLOSURES:</u>

A. A patient has a right to request a history of disclosures of their patient information.

B. An accounting of disclosures can be provided upon request once a year at no charge. Additional requests in the same twelve (12) month period may be assessed a fee.

C. Upon receiving a report of a potential breach of PHI, this practice, and any qualifying business associates, will follow the mandated breach notification procedures outlined in the HIPAA Security Rules.

IV. <u>PATIENT ACCESS TO MEDICAL RECORDS: ASK IN PERSON OR CALL (215) 793-4546</u>

A. A patient's medical record is accessible to the patient, or guardian, for review by request in writing. This review must be done in the presence of their clinician or a person designated by their clinician. The following items <u>may be excluded</u> from the record being reviewed:

1. Psychotherapy notes, identified as those notes kept separate from the remainder of the patient record.
2. Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.
3. Information that, if disclosed, is likely to endanger the life and physical safety of you or another person.

B. A patient, or guardian, may request a copy of the accessible patient's record. If the requesting Individual agrees, a summary or explanation of the record may be provided. If the requesting individual does not agree to a summary of the record, a copy of the record may be provided. A charge of a reasonable, cost-based fee will be assessed for providing either a summary or copies of a patient record and must be paid prior to the release of the record information. The following items <u>may be excluded</u> from the record being copied:

4. Psychotherapy notes, identified as those notes kept separate from the remainder of the patient record.
5. Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.
6. Information that, if disclosed, is likely to endanger the life and physical safety of you or another person.

C. A patient, or guardian, has the right to make a request in writing, of their clinician for amendment to their individual record if they feel it is inaccurate or incomplete. A request to amend the record can be accepted or denied by the clinician. An appeal of any denial may be filed, subject to a rebuttal statement from the clinician.

D. A patient has the right to a paper copy of this notice, and may ask to receive a copy at any time.

E. A patient has the right to restrict certain disclosures when they have paid out-of-pocket to health plans, unless for treatment purposes or if the disclosure is required by law.

V. <u>QUESTIONS AND COMPLAINTS:</u>

A patient, or guardian, may direct any and all questions regarding this Notice to the practice Privacy Officer by calling 215-793-4546 and ask for Jeanne Fleischer. Should a patient, or guardian, feel their confidential information has been disclosed inappropriately, they have a right to file a complaint with our Privacy Officer, or with the Secretary of Health and Human Services, Office of Civil Right, 200 Independence Avenue SW, Washington, DC 20201.