www.mindnbodymd.com mail@mindnbodymd.com
420 64th Street Brooklyn, NY 11220 | T. 718-630-1310 | F. 718-630-1313
32-72 Steinway Street, Suite 501 Astoria, NY 11103 | T. 718-204-9720 | F. 718-204-9722

**Please Complete All Sections**

**Patient Information**

Name (First, MI, Last)_____Date of Birth_____/_____/_____ Sex: □M □F
SS#_____ Marital Status:□ Single □ Married □ Divorced □ Widowed □ Separated
Mailing Address (street)_____Apt#_____
City _____ State _____ Zip_____
Primary Phone (_____)-_____-_____ Secondary Phone (_____)-_____-_____
Email Address _____
Employer Name _____ Phone # (_____)-_____-_____
Employer Address_____

**I am seeking: ☐Psychiatry/Medication Management ☐Psychotherapy ☐Addiction Medicine**

**Would you like to activate your patient portal? □ Yes □ No**

**Other family members that are patients:_____**

**If patient is UNDER 18 YEARS OLD, Parent/Guardian, or Responsible Party Information**

Name (First, MI, Last)_____Date of Birth _____/_____/_____ Sex: □M □F
Mailing Address (street) _____Apt#_____
City _____State _____Zip_____
Home Phone (_____)-_____-_____Daytime Phone (_____)-_____-_____SS#_____
Employer _____ Phone Number (_____)-_____-_____
Employer Address_____
Patient's relationship to Insured: □Self □Spouse □Child □Stepchild □Other

**Insurance Card**

Name of Policy Holder (Insured) _____Date of Birth _____/_____/_____
Insurance Comp. Name _____Insurance Phone# (_____) -_____-_____
Policy Holder's Social Security # _____ Policy # _____
Group # _____
Patient's relationship to Insured: □Self □Spouse □Child □Stepchild □Other

**Prescription Drug Card** (if applicable)

Name of Policy Holder (Insured) _____Date of Birth _____/_____/_____
Insurance Comp. Name _____Insurance Phone# (_____) -_____-_____
Policy Holder's Social Security # _____ Policy # _____
Group # _____
Patient's relationship to Insured: □Self □Spouse □Child □Stepchild □Other

**In case of emergency (Please list someone, who does not live with you)**
**Name_____ Relationship to patient _____**
**Address_____Phone#(_____) -_____-_____**

**Pharmacy Information**

Pharmacy Name_____
Address/Cross Streets_____ Phone # (____)-_____-_____

**How did you hear about Mind & Body Wellness medical center? _____**

**Assignment of Benefits: I authorize the release of any medical or any other information necessary to process this claim(s). I authorize the direct payment of medical benefits to the physician. I am aware of my responsibility for payment for services not covered. I have read the Payment Policy and Release of Information described on page 2. I understand and agree to all its provisions.**

X_____ Date _____/_____/_____
PATIENT / GUARDIAN SIGNATURE

**Initial: _____**
**Date: _____**

www.mindnbodymd.com mail@mindnbodymd.com
420 64th Street Brooklyn, NY 11220
T. 718-630-1310 | F. 718-630-1313
32-72 Steinway Street, Suite 501 Astoria, NY 11103
T. 718-204-9720 | F. 718-204-9722

# GENERAL CONSENT FOR TREATMENT

For patients seeking outpatient services:

1. I am asking for medical care and treatment at this facility and agree to accept services which may diagnose a psychiatric condition, procedures to treat my condition and routine care. I understand that these services will be provided to me by psychiatrists and licensed social workers. I have not been given any guarantees as to the results of the services I will receive.
2. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.
3. I understand that my agreement to accept these services is called General Consent.

## NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**TREATMENT:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing psychiatric conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical records to all health professionals that may provide treatment or who may be consulted by staff members.

**PAYMENT:** Your health information may be used to seek payment from your health plan. For example, your health plan may request & receive information on dates of services, services provided & psychiatric condition being treated.

**APPOINTMENT REMINDERS:** We may call you, speak to you or leave a message with someone or on an answering machine regarding your upcoming appointment.

**LAW ENFORCEMENT:** Your information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

**PUBLIC HEALTH REPORTING:** Your information may be disclosed to public health agencies as required by law, for example, we are required to report certain communicable diseases to the state's public health department.

**TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY:** We may disclose information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**WORKER'S COMPENSATION AND DISABILITY:** We may release information about you to Worker's Compensation programs, disability insurers, or the Social Security Administration. In certain instances, such information may be released to your employer.

**OTHER:** uses and disclosures require your authorization, disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

I have received the notice of privacy practices and I have been provided an opportunity to review it.

_____ _____
Signature of Patient/Legal of Minor Patient Date

If the patient cannot consent for him/herself, the signature of either the healthcare agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

_____ _____
Signature of Health Care Agent/Legal Guardian Date

**Initial: _____**
**Date: _____**

www.mindnbodymd.com mail@mindnbodymd.com
420 64th Street Brooklyn, NY 11220
T. 718-630-1310 | F. 718-630-1313
32-72 Steinway Street, Suite 501 Astoria, NY 11103
T. 718-204-9720 | F. 718-204-9722

# Controlled Substance Policy

At Mind and Body Wellness Medical Center we prescribe narcotic medication very carefully. That is because abuse of prescription narcotics has exploded into a national epidemic. In fact, accidental death from overdose of prescription narcotics now exceeds that of heroin and cocaine combined.

For our patients' safety, Mind and Body Wellness physicians and advanced practitioners evaluate each patient's situation and develop a plan that considers all available options, including psychotherapy or medication management.

Patients who are prescribed narcotics are required to perform periodic random urine drug testing for other drugs (including illegal or unauthorized prescription drugs) that may cause dangerous interactions. This helps to ensure that patients are safe and that we are in compliance with the state's strict prescribing guidelines.

New patients to Mind and Body Wellness who have been prescribed narcotic medication in the past by other doctors will be carefully evaluated by their new physician to determine the best course of treatment. Therefore, we ask new patients to understand that previous use of narcotic pain medication does not mean that these medications will automatically be prescribed or renewed by the prescribers.

All Mind and Body Wellness providers follow the same safe narcotic prescribing procedures. Patients felt to be at risk for withdrawal from chronic narcotic use may be counseled to seek care at a drug detox center.

At Mind and Body Wellness Medical Center, our goal is always to provide patients with the safest and most appropriate care. We ask for our patient's assistance in ensuring the proper use of narcotic medication.

I have received the controlled substance policy and I have been provided an opportunity to review it and agree to perform the urine drug test when asked.

_____ _____
Signature of Patient/Legal of Minor Patient Date

If the patient cannot consent for him/herself, the signature of either the healthcare agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

_____ _____
Signature of Health Care Agent/Legal Guardian Date

**Initial: _____**
**Date: _____**

www.mindnbodymd.com mail@mindnbodymd.com
420 64th Street Brooklyn, NY 11220 32-72 Steinway Street, Suite 501 Astoria, NY 11103
T. 718-630-1310 | F. 718-630-1313 T. 718-204-9720 | F. 718-204-9722

## Release of information and assignment of benefits:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Mind & Body Wellness Medical Center** or insurance company to release any information required to process my claims.

In addition, I acknowledge that I have been informed of the **Mind & Body Wellness Medical Center's** Notice of Privacy Practices. I understand **Mind & Body Wellness Medical Center** is a HIPAA compliant office. As a patient, I have the right to obtain a copy of the Notice of Privacy Practices at any time.

## Payment Policy

Our mission at **Mind & Body Wellness Medical Center** is to deliver excellent and personal care that positively impacts people in a changing healthcare system. Our payment policy was created to reduce administrative costs to keep our fees as low as possible for our patients.

Payment is required at the time of service. Any applicable co-payments, co-insurance, negotiated payment plans and/or deductibles are due at the time of service. For patients with medical insurance benefits, we will bill your insurance. For patients without insurance, we accept payment in the form of cash or credit/debit card. All charges incurred at **Mind & Body Wellness Medical Center** are ultimately the responsibility of the patient, regardless of insurance benefits.

At **Mind & Body Wellness Medical Center** we want to manage our time efficiently, so we can deliver excellent personal care to our patients. We request a 24-hour notice (call, text, or email) for all cancellations/reschedules. If you no-show for your appointment you will be charged $25 on the second occurrence. This fee is not covered by insurance and is the sole responsibility of the patient. Please understand this policy is to ensure efficient time management, so all patient's get the time they need with our medical providers.

A fee will be charged for any voided payments.

I have received the notice of payment policy and I have been provided an opportunity to review it.

_____ _____
Signature of Patient/Legal of Minor Patient Date

**Initial: _____**
**Date: _____**

www.mindnbodymd.com mail@mindnbodymd.com
420 64th Street Brooklyn, NY 11220
T. 718-630-1310 | F. 718-630-1313
32-72 Steinway Street, Suite 501 Astoria, NY 11103
T. 718-204-9720 | F. 718-204-9722

# CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

**PATIENT'S NAME:** _____

**NAME, AS IT APPEARS ON CREDIT CARD:** _____

**BILLING ADDRESS:** _____

**EMAIL ADDRESS:** _____

**AMEX/DISC/MC/VISA CARD #** _____

**EXPIRATION DATE:**_____/_____**VERIFICATION CODE (3 or 4 DIGITS)**_____

**PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE**

I acknowledge and authorize Mind and Body Wellness Medical Center to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run on the day of my appointment. I agree to receive billing statements, invoices, and receipts via the email I have provided to this office. If I am an uninsured patient, I authorize payment at time of service. I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date

**Initial:** _____
**Date:** _____