SCOTT A. FLEISCHER, M.D., & ASSOCIATES
455 PENNSYLVANIA AVE, SUITE 260
FORT WASHINGTON, PA. 19034
Ph) 215-793-4546 Fx) 215-793-9007

Dear Patient,

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

Your first initial appointment is with_____, on_____. Your second appointment is with_____, on_____.

1. **___ INITIAL CANCELLATION FORM**
2. **___ PATIENT REGISTRATION FORM**
3. **___FINANCIAL POLICY AGREEMENT**
4. **___INFORMED CONSENT FOR TREATMENT/AUTHORIZATION TO PAY**
5. **___PROVIDER COMMUNICATION FORM**
6. **___MEDICAL HISTORY /PAST & FAMILY HISTORY**
7. **___HIPPA NOTICE OF PRIVACY PRACTICES (FOR YOU TO KEEP)**

Please mail completed forms by the requested date above. The forms are needed, at the latest, 48 hours before the scheduled appointment or your appointment may have to be rescheduled.
We require that all patients arrive 15 minutes prior to the start of your appointment. This is to ensure that you are checked in and available to begin your session on time. If you arrive 10 minutes after your scheduled appointment time, you may need to be rescheduled. You also may be assessed a fee.
If you cannot make your appointment and need to reschedule or cancel your appointment, we require 2 business days' notice to avoid a charge.
Please bring your photo ID, insurance card, and any co-payments with you when you come for your appointment.
We look forward to meeting with you.

Thank you,

Scott A. Fleischer, M.D., P.C., & Associates

Scott A. Fleischer, M.D., P.C., & Associates
455 Pennsylvania Avenue • Suite 260 • Fort Washington, Pennsylvania 19034
Phone: (215) 793-4546 • Fax: (215) 793-9007

PATIENT REGISTRATION FORM

All yellow sections must be completed

Patient Name _____ **Date of Birth** _____
(as it appears on your insurance card)

☐Male ☐Female ☐Transgender ☐Other_____(Please specify)

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 I give you permission to text my cell phone – data charges may be incurred.

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** _____

Is this Emergency Contact also your HIPAA Contact to discuss your Medical Information? __ Yes __ No

Insurance Subscriber's Name_____ **Subscriber's Employer** _____

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

Pharmacy Name _____ **Pharmacy Phone #** _____

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 _____ Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

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

Discussion of Medical Care and insurance:

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.**

OR

☐ ***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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FINANCIAL POLICY AGREEMENT

All yellow sections must be completed

Patient (print) _____ **Date of Birth** _____
(as it appears on your insurance card)

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 **($125.00, 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, delayed 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.

LATE FEE

We set aside the appropriate amount of clinical time for your appointment on the date that you chose. We require patients to **arrive 15 minutes prior to the start of their session**. If you arrive 10 minutes after the start of your scheduled appointment (session) time, you will be charged a $25.00 late fee to cover clinical time that cannot be billed to your insurance company. Depending on how late you are you may need to reschedule and will instead need to pay the $75.00 missed appointment fee.

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 if you request record copying, mailing or preparation of reports. This fee is regulated by the State of Pennsylvania. Therapy over the phone will be assessed a fee that is due prior to the session, and is not covered by insurance. 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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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): _____

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INFORMED CONSENT FOR TELEMEDICINE TREATMENT

I further agree and consent to receive the above services from Scott A. Fleischer, M.D., P.C. & Associates through the use of telemedicine technology.

I understand that there are risks associated with the use of telemedicine technology as provided through the internet, such as the potential for my information to be stolen by third parties. I understand that Scott A. Fleischer, M.D., P.C. & Associates will maintain the security of my personal information as required by law, but I acknowledge that such information can still be intercepted by third parties some instances.

I further acknowledge that treatment through telemedicine technology may not include certain aspects of treatment that would otherwise be provided in person, such as the ability to physically interact with or otherwise benefit from being in the same room as my providers.

I further agree that I am responsible for maintaining privacy of the viewing and listening area where I will be for any telemedicine services, including ensuring that no other people can hear or see me during the telemedicine service.

I understand that telemedicine services require the use of audio-visual transmissions over the internet, and that I am responsible for maintaining my own internet connection. I further acknowledge that Scott A. Fleischer, M.D., P.C. & Associates shall not be responsible for any connection problems due to my internet connection or my internet service provider.

Acknowledging and accepting all of the above information, I agree to receive the telemedicine services.

_____ _____

Signature of patient or responsible party **Date**

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PROVIDER COMMUNICATION RELEASE

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

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.

Release Agreement: I agree to release: (check one)

_____ **any applicable mental health/substance abuse information to my physician or therapist**

_____ **only medication information to my physician or therapist**

_____ **I do not give my authorization to release any information to any physician or therapist.**

Primary Care Physician	**Phone Number**
Address	**Fax Number**

Psychologist or Therapist 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.

All of the above information is current and correct:

Patient Signature: _____ **Date**: _____

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New Patient Evaluation Form – MEDICAL HISTORY

Please complete all applicable lines

Patient's Name _____**Date of birth**____/___/____ **Today's Date** ____/___/____
Age_____ **Referring Doctor** _____**Tel.#**_____
Pharmacy_____**Tel.#**_____
Chief Complaint: __agitated _ depressed __wandering __anxious__other_____

History of The Present Illness- Please check all symptoms below that apply:

___**Mood**: depressed/euphoric/variable /mixed mood
___ **Sleep**: initial/middle/insomnia early awakening/ ⇑ sleep
___**Interest level**: __ increased__decreased
___**Energy level**: __ increased__decreased
___**Concentration:** __ decreased
___**Guilty feelings:** _____
___**Hopelessness /Worthlessness/Suicidal Ideation/Plan**_
__**Appetite:** __ ⇑ __ ⇓ __wt. Δ (___lbs.)/time_____
___**Anxiety**: __ calling out __ Panic attacks
___**Heart races/short of breath/sweating/run away/nausea**

___**Feel euphoric**
___**Racing Thoughts** __Shopping Sprees __Talk fast
___**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:** _____

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(Cont. on page 4)

LABS:_____
_____

CURRENT MEDICATIONS (name, dosage, frequency):

1._____4. _____7._____10. _____
2._____5. _____8._____11._____
3._____6._____9._____12._____

Allergies _____

New Patient Evaluation Form - PAST & FAMILY HISTORY

Please complete all applicable lines

Patient Name _____ **Date of birth**____/____/____

PAST PSYCHIATRIC HISTORY **(please write N/A if no history)**

Treatment & Hospital: (include dates & reason)_____

Antidepressants_____

Dementia_____

Antipsychotics _____

Antianxiety/Sleep Agents _____

Antimanic/Mood Stabilizers _____

ADHD Drugs _____

FAMILY PSYCHIATRIC HISTORY **(please write N/A if no history)**

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Key Life Events that Impacted your Life: (please write N/A if no history of notable events)

_____

_____

_____

_____

Education/ Highest Grade completed _____

Marriage/Dating _____

_____

Work_____

_____

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

_____

PAST MEDICAL HISTORY

Past Medical History _____

_____

Past Surgical History _____

_____

CURRENT MEDICAL ISSUES:

Current Medical Diagnosis _____

_____

Please list your Primary Care Doctor _____ **Phone**_____

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THIS FORM IS FOR YOU TO KEEP

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
3. 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.

4. 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. ACCOUNTING OF DISCLOSURES:

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. PATIENT ACCESS TO MEDICAL RECORDS: ASK IN PERSON OR CALL (215) 793-4546

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 may be excluded 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 may be excluded from the record being copied:

5. Psychotherapy notes, identified as those notes kept separate from the remainder of the patient record.
6. Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.
7. 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. QUESTIONS AND COMPLAINTS:

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.