John Panzone Psychiatry PLLC
1133 Pleasantville Rd, Suite 2A
Briarcliff Manor, NY 10510
Phone 914-236-4147
Fax: 914-238-1697

PATIENT DEMOGRAPHIC INFORMATION FORM

Today's Date _____

PATIENT INFORMATION:

Patient's Name _____

Address _____

City _____ State_____ Zip _____

Home Phone#_____Cell#_____Work#_____

Email address_____

Age_____Date of Birth_____

Sex_____

Married_____ Single_____ Divorced_____ Other_____

Employer _____ Occupation _____

Pharmacy Name/City _____Phone#_____

REFERRAL INFORMATION:

Referred by _____Phone#_____

PRIMARY CARE PERSON AND OTHER PHYSICIANS:

Family Physician_____Phone#_____

OB/GYN_____Phone#_____

Cardiologist_____Phone#_____

Neurologist_____Phone#_____

Other Specialist_____Phone#_____

EMERGENCY CONTACT INFORMATION:

Name_____Relationship_____

Address_____

Cell#_____Home#_____Work#_____

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MEDICAL HISTORY

Please list all current medications that you are taking, both psychiatric and non-psychiatric, including vitamins and supplements. Include dose and when they are taken.

Medication Name	Condition medication used for
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current medical conditions:

Previous medical conditions/surgeries:

Allergies to medications:

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PAYMENT AND INSURANCE INFORMATION AGREEMENT

I fully acknowledge that I am responsible for **full payment** of the total bill incurred, and that I will need to pay Dr. Panzone within 30 days after each appointment.

I fully acknowledge that I am responsible for filing my own forms to my insurance company.

I understand that it is my responsibility to know what my insurance company requires in order for me to be reimbursed, and that I need to let Dr. Panzone know this information in advance.

I understand that if there are delays in payments, or problems with receiving reimbursement from my insurance company, that it is my responsibility to contact my insurance company.

By signing below, I acknowledge that I have read and understand the above, and I agree to these terms.

_____Date_____

Signature of person responsible for payment

_____

Print name

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RELEASE OF MEDICAL INFORMATION TO YOUR INSURANCE PROVIDER

Do you have health insurance? Yes_____No_____ (If yes, complete the following form)

Primary Insurance Company_____

Policy Holder_____Relationship_____

Group#_____ID#_____

This signature is to authorize the release of any necessary medical information to my insurance provider (i.e. if prior authorization is required for medications).

All clinical information about me may be released, including my diagnoses, lab results, and information about substance use.

By signing below, I fully acknowledge that I have read this form and agree to the terms as outlined above.

_____Date_____

Patient Signature

_____

Print name

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TELEHEALTH CONSENT

Telehealth involves the use of synchronous electronic communications to enable clinicians and patients to work together remotely.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and date and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Dr. Panzone uses a HIPAA compliant telehealth service.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site)
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

Telehealth may present privacy considerations not present in traditional office-based practice. There potential risks associated with the use of telehealth include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

By signing this form, I attest to and understand the following:

1. In compliance with the Ryan Haight Act, no controlled substances will be provided via telehealth appointments prior to having an in-person appointment.

2. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.

3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My clinician has explained the alternatives to my satisfaction.

5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

6. I agree that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter

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CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telehealth, have discussed it with my clinician, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care, and hereby authorize my clinician to use telehealth in the course of my diagnosis and treatment.

If you have questions about telehealth, please ask Dr. Panzone.

Your signature acknowledges that you have read the above statement and agree to these conditions.

_____Date_____

Patient Signature

_____

Print name

CONSENT TO SEND TEXT MESSAGES

By signing below, I attest to and understand the following:

1. I give consent to receive SMS (text) messages from Dr. Panzone.
2. Use of text messaging is NOT HIPAA compliant, however Dr. Panzone will not send any private health information (as defined by HIPAA) in text.
3. Data and messaging rates may apply to each message sent.
4. I can opt out of receiving SMS messages at any time by notifying Dr. Panzone.

Your signature acknowledges that you have read the above statement and agree to these conditions.

_____Date_____

Patient Signature

_____

Print name

PRIVACY POLICY

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It is my policy to not release any information regarding your use of my services or your private and confidential information. However, with your written permission, my psychiatric services are better in collaboration with your therapist and any medical providers you may have.

I use an internet-based, medical record system, prescription program, and telehealth provider. I, and those companies, am/are all required to keep your information protected under the requirements from the Health Care Information Portability and Accountability Act (HIPAA).

The following conditions affect the confidentiality of your information:

1.) You may choose to provide written permission for me to release your records or other information about you, to anyone by filling our "Release of Information" form.
2.) If I assess you to be at imminent risk of harming yourself or of harming someone else, then I am legally and ethically obligated to follow certain procedures and disclose information about you to try and keep you safe, and to try and keep anyone else who might be in danger safe.
3.) I am required, under New York law, to report to the proper agency and/or authorities, any information about reported or suspected child or elder abuse. Once this information is reported, the proper agencies and/or authorities may gather additional information and/or decide to conduct a formal investigation.
4.) A court order, written by a judge, could require me to disclose your private information, but that happens **very rarely.** I would notify you of such a court order, prior to disclosing any of your information, so that we can discuss this together with your legal counsel. If this were to happen, I would do my best, within the law, to try and limit the information shared about you, to only the information needed to answer the legal questions or charges.

If you have questions about this privacy policy, please ask me.

Your signature acknowledges that you have read the above statement and agree to these conditions.

_____Date_____

Patient Signature

_____

Print name

OFFICE POLICIES AND PROCEDURES

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The following information is intended to explain policies and procedures of services provided by Dr. John Panzone. Please read through the details thoroughly and discuss and questions you may have prior to signing it.

A.)AVAILABILITY: Dr. John Panzone has an individual, private, part-time, psychiatry practice whose service is intended to compliment the services you receive from your primary care provider and your individual therapist. Appointments to be made with Dr. Panzone based on availability.

B.)PAYMENT: For your insurance company purposes, Dr. John Panzone is an **"Out-of-Network Provider"**. Payment is required within 30 days of appointment. Upon request, you will be given an invoice listing services and fees. This document also contains the information required by most insurance companies for out-of-network reimbursement. You may attach the form you receive from our office to your insurance claim form and submit it by mail to your insurance company for reimbursement. Please know, the responsibility for filing these is entirely yours. Please understand that you, not your insurance company, are responsible for full payment of your account. Please consult with your insurance so that you understand the requirements, costs, correct form to submit, and their reimbursement rates. Emailed invoices will include an online payment link.

C.APPOINTMENTS:

1.) **Brief Phone Call:** After reaching out to Dr. Panzone, we will have a brief phone call to discuss your treatment needs. It is on this brief phone call where an initial appointment will be made.

2.) Initial appointment: Your initial appointment will last for 60 minutes. The initial appointment is considered a consultation and involves **history gathering, safety evaluation, and diagnosis only.** In some cases, no psychiatric medication is prescribed at this initial appointment. Either during or after your initial appointment, Dr. Panzone will gather additional information, with your written permission and as needed, from secondary informants (for example from family members, significant other, and previous providers.) A tentative second appointment time may be scheduled with you at the end of your initial appointment. Dr. Panzone will then contact you if he is able to be your psychiatrist. This decision is based on his evaluation of your needs, and appropriateness of fit, based on the level of care needed, and types and amount of services this practice is able to provide to you.

3.) Second appointment: Your second appointment will last up to 30 minutes. Dr. Panzone will review your diagnoses, provide education, and establish an initial treatment plan with your input and approval. Any relevant forms will be reviewed and signed by you. By the end of the second appointment, ***if*** an actual treatment plan agreement is established, Dr. Panzone will then be your psychiatrist. If a treatment plan agreement is not established, this practice is not required to find you a psychiatrist, but Dr. Panzone may discuss with you and your referring provider possible recommendations.

4.) Follow-up Medication Management Sessions: Follow-up medication management appointments are scheduled with Dr. Panzone. In general, plan on meeting with him about more frequently at the beginning of treatment and as stability is achieved, the appointments can be spaced out more. Patients prescribed controlled substances will be seen once monthly.

We recommend you arrive 15 minutes early before your initial appointment, and then between 5-10 minutes early for follow-up appointments.

D.)COMMUNICATIONS:

1.) Phone Calls and Voicemails: Dr. Panzone will review voicemails and messages at least three times each day during regular business hours. When you call, you can leave a non-urgent voicemail, or to communicate a more urgent message, you can send a text message to the office number. Non-urgent calls will be returned within 24 hours, or the next business day if on a weekend or holiday. Dr. Panzone makes every effort to reply to all calls within a reasonable time, but does not interrupt another patient's session to answer phone calls. Dr. Panzone will try to return urgent messages within 2-3 hours, or as soon as he is able to call you. When you call/leave message,

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please leave your full name, date of birth, phone number, reason you are calling, and Dr. Panzone will reply. **Please let our office know if it is not O.K. to leave voicemails or text messages at your preferred contact number.*

2.) Email: Email sent by patients is for **non-urgent communications only.** You will receive an email confirmation of scheduled appointment, appointment reminders, and a link to the telehealth appointment.

3.) Patient Portal: Dr. Panzone uses a HIPAA compliant patient portal.

a.) Here, you can securely send messages about your treatment or copies of any previous records directly to Dr. Panzone.
b.) Review billing statements and payment history.
c.) Find all practice forms in the "Document" section. Please review, complete and sign required forms prior to initial appointment. Forms can all be completed and signed electronically. Dr. Panzone can also mail these practice forms to you if needed.

E.) CHARTING AND PRESCRIPTIONS: Our office uses state-of-the-art, web-based electronic medical record and web-based medication prescribing systems; which maintain your records confidentially, under the HIPAA requirements, and make it safer to get medications and refills.

F.) MEDICATION REFILLS: Medication evaluation, dose adjustment, and refills are all done during your appointments. During follow-up appointments, Dr. Panzone will provide you with refills to last until your next scheduled appointment. Please try to anticipate your medication needs and call for refills only during regular business hours. Please do not wait to call until you run out of your medication; give several days' notice to allow Dr. Panzone time to place the prescription. If for some reason you miss your appointment, please inform this practice if you need medication to last until your next appointment. No refills will be provided until another appointment is scheduled. Medication refills will not be provided if you have gone beyond 6 months without evaluation by Dr. Panzone; at that time, you must be evaluated in person (or via telehealth) to get medication refills.

G.) CHARGES, FEES, OUTSTANDING BALANCE:

1.) Fee for initial appointment and any subsequent appointments will be discussed prior to scheduling initial appointment.
2.) Administrative Time Fee: If you need Dr. Panzone to communicate by phone with your insurance company, or for other miscellaneous needs, that cannot be addressed during your appointment time. This includes special documentation preparation such as workers compensation, advocacy letter, employment, disability, etc.
3.) Printing and photocopy charges may be applied for documentation requests.
4.) Returned Check Fee: If a check is returned due to insufficient funds, a $25 additional fee is charged.
5.) Cancellation Fees: see below, Cancellation Policy.
6.) Outstanding Balances: If you do not arrange a payment plan, accounts outstanding for more than 90 days will be sent to our collection agency.
7.) Payment Plans: Payment plans are available to divide your outstanding bill to equal monthly payment installments. Payment plans will include keeping an active credit card on file.

H.) MISSED APPOINTMENT AND CANCELLATION POLICY:

1.) If you cancel or reschedule your appointment **at least 24 hours** prior to your appointment time, you will not be charged any fees.

2.) If you cancel or reschedule an appointment **less than 24 hours** prior to your appointment time or miss the appointment completely (a no-show for the appointment), then you may be charged a fee for your missed or cancelled appointment.

a.) 1st no-show for an appointment or cancellation less than 24 hours prior to your appointment will not be charged a fee.

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b.) 2nd no-show for an appointment or cancellation less than 24 hours prior to your appointment will result in a fee equivalent to ½ the amount of the visit fee.
c.) 3rd no-show for an appointment or cancellation less than 24 hours prior to your appointment will result in a fee equivalent to the full of amount of the visit fee.
3.) Exceptions will be dealt with on a case-by-case basis and are at the discretion of Dr. Panzone.

4.) Please call our office as soon as you know will either miss, or not arrive in time for your appointment.

**Please note that most insurance carriers will not reimburse you for cancelled or missed appointment fees. Please also check with your insurance company prior to see if they reimburse for video (telehealth) sessions.*

I.) TERMINATION OF CARE:

1.) If your mental health needs are too great to be safely managed by a part-time individual psychiatrist, Dr. Panzone reserves the right to refer you to more appropriate psychiatric care (for example a full-time psychiatric group, a psychiatric hospital, or mental health clinic) who can better and more safely meet your needs.

2.) Any of the following may be grounds for termination of care:

a.) Refusal at any time to allow Dr. Panzone to communicate with your primary support network, or current or previous mental health providers.
b.) Refusal or non-adherence to your treatment plan, established and agreed to by you and Dr. Panzone, including completion of necessary lab-work and prompt random drug screening.
c.) Suspected misuse or over-use or diversion of controlled substances.
d.) Missing an unreasonable number of appointments.
e.) More than one bounced check or significant unpaid balances.
f.) Not agreeing to set up a reasonable payment plan for unpaid balances.

J.) EMERGENCIES:

In the event of a psychiatric emergency, please call 911, or call the National Suicide Prevention Lifeline at 1-800-273-8255, or find a way to safely get to your nearest emergency room. Please make sure Dr. Panzone is contacted by whoever evaluates you during the emergency.

IF YOU ARE NOT SURE IF YOUR SITUATION IS URGENT OR AN EMERGENCY, PLEASE BE ON THE SAFE SIDE AND TREAT IT LILKE AN EMERGENCY. REMEMBER THAT IT COUULD BE SEVERAL HOURS BEFORE DR. PANZONE IS ABLE TO RETURN AN URGENT PHONE CALL. PLEASE PLAN AHEAD FOR MEDICATION REFILLS, AS THESE REQUESTS ARE SOMETIMES NOT CONSIDERED EMERGENCY SITUATIONS.

Your signature acknowledges that you have read the above statement and agree to these policies and procedures.

_____Date_____

Patient Signature

_____

Print name