PATIENT IDENTIFICATION FORM

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle Initial

Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip Code

Permanent Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( if different)

 Street City State Zip Code

Telephone: (M) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: ( ) Male ( ) Female ( ) Other

Marital Status: ( ) Single ( ) Married/Partnered ( ) Separated ( ) Divorced ( ) Widowed

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Driver’s License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State issued: \_\_\_\_\_\_\_\_\_\_

**Please Sign Below:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Authorization Form**

 I, the undersigned individual, authorize Manhattan Wellness Psychiatry. PLLC to charge my credit card for outstanding payments on all services rendered. I am also authorizing charges for any appointments missed or rescheduled within less than a 24 hour notice as per this practice policy.

I authorize Manhattan Wellness Psychiatry. PLLC to charge my credit card for the full amount due for the services provided.

I understand this form will be securely stored in my clinical file and may be updated, or voided upon my request at any time.

Card Type (please circle one): Visa MasterCard Discover American Express

Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (as printed on card):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verification/Security Code (3-digit code or 4 digits for AMX): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Financial Agreement**

Please acknowledge that Manhattan Wellness Psychiatry. PLLC is authorized to bill your enrolled insurance company on your behalf to get reimbursed for the services given to you. If payment is denied by insurance company for any reason you will be liable for the full payment due within 30 days of the invoice using the credit card on the file. Full session payment will also be charged for lateness, missed or inappropriately rescheduled sessions as delineated in Manhattan Wellness Psychiatry. PLLC practice policy.

Office will maintain your credit card information on file and if self pay, process the charge at the time of performing a service.

An excessive outstanding balance can interfere with the therapeutic relationship, thereby making effective treatment difficult or impossible. Please be advised that the date and time of failure to pay dues for services provided which are not in accordance to the mutually agreed prior arrangements, will be considered as a date and time when termination of existing doctor patient professional relationship has been initiated.

By signing below, I attest that I have read, understood and that I consent to the aforementioned financial agreement:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_

Medical care can become expensive. If you have concerns about your ability to pay please discuss your financial situation with the provider as soon as possible in order to create a plan of action that will prevent the occurrence of any unpaid balance.

Emergency Agreement

None of us ever wish to be faced with times of emergency, but if we must endure such a time, then it is good to be prepared.

In case of an emergency please call 911. You may rightfully attempt to reach your

Psychiatrist as well in this difficult time, but please do so AFTER calling 911, as your

safety is of utmost importance.

As well, when contacting your psychiatrist, please do so by phone (never by text

messaging or email) to ensure timely and confidential delivery of the information.

Having a proper emergency plan, and knowing the actions necessary to carry out the

plan, will most certainly ensure a safe and successful outcome.

All the best to you,

Manhattan Wellness Psychiatry

Nidhi Goel, MD PLLC

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **HIPAA PRIVACY POLICY ACKNOWLEDGEMENT/AGREEMENT**

This notice describes how your health information, as a patient of Manhattan Wellness Psychiatry; PLLC. Nidhi Goel, MD may be used and disclosed, as well as how you can get access to your health information. This is required by the Privacy Regulations created as a result of the “Health Insurance Portability and Accountability Act” of 1996 (HIPAA). Our Commitment to your privacy: Your Clinician is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances: (The following circumstances may require your clinician to use or disclose your health information.)

1. To public health authorities and health oversight agencies that are authorized by law to collect information.2. Lawsuits and similar proceedings in response to court or administrative order.

3. IF required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat and protect from harm.

5. If you are a member of the U.S. or a foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official.

8. For Workers Compensations and similar programs.

**Your rights regarding your health information:**

1. Communications: You can request that your clinician communicate with you about your health and related issues in a

particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We

will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or information to

only certain individuals involved in your care, the payment of your care, such as family members and friends. We are not

required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required

by law or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you

including patient medical record and billing records, but not including psychotherapy notes. You must submit your request in

writing to your clinician at: Manhattan Wellness Psychiatry PLLC, Nidhi Goel, MD, and emailing it to mwpsychiatry@nidhigoelmd.com or faxing at the number provided above.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information

 is kept for your clinician. To request an amendment, your request must be made in writing and submitted to your clinician at:

Manhattan Wellness Psychiatry, PLLC, Nidhi Goel, MD 116 West 23rdSt, Suite 71- 5th floor, NY NY 10011

5. Filing a Grievance: You have the right to file a complaint. If you believe that your privacy rights have been violated, you may

file a complaint with your clinician or with the Secretary of the Department of Health and Human Services. To file a complaint

with your clinician, please submit in writing to your clinician at: Manhattan Wellness Psychiatry, PLLC,

Please note, you will not be penalized for filing a complaint.

6. Right to a copy of this notice at any time: You are entitled to receive a copy of this Notice of Privacy Policies. You may ask

us to give you a copy at any time. To obtain a copy of this notice, contact your clinician’s front reception desk.

7. Right to provide an authorization for other uses and disclosures: Your clinician will obtain your written authorization for uses

and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our Health Information Privacy Policies, please contact your physician/clinician at (646)812-5355. Please, sign the second page of this Privacy Policy to acknowledge your receipt of this information.

Thank you,

Psychiatric and Psychological Affiliates of Manhattan Wellness Psychiatry,

Nidhi Goel, MD PLLC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY (HIPAA) AGREEMENT

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have received a

copy of the Manhattan Wellness Psychiatry, PLLC Nidhi Goel, MD “HIPAA Privacy

Policy Acknowledgement Agreement” form.

This notice describes how Manhattan Wellness Psychiatry, Nidhi Goel, MD PLLC

may use and disclose my protected health information, certain restrictions on the use

and disclosure of my healthcare information, and rights I may have regarding my

protected health information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

• Patient medical records

• Medical images

• Live two-way audio and video

• Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

**Expected Benefits:**

• Improved access to medical care by enabling a patient to remain in his/her provider’s office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.

• More efficient medical evaluation and management.

• Obtaining expertise of a distant specialist.

**Possible Risks:** As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks 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 reactions or other judgment errors;

Please initial after reading this page: \_\_\_\_\_\_\_\_\_\_

Informed Consent for Telemedicine Page 2

**By signing this form, I understand the following:** 1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which

identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of

telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the

course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

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 provider has explained the alternatives to my satisfaction.

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my

care, but that no results can be guaranteed or assured.

**Patient Consent To The Use of Telemedicine**

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Dr. Nidhi Goel from Manhattan Wellness Psychiatry. Pllc to use telemedicine in the course of my diagnosis and treatment.

*Signature ofPatient:*

 *Name of patient: Date:*

*:*

I have been offered a copy of this consent form (patient’s initials) \_\_\_\_\_\_\_