ALLAN L. LEVY, MD, PC
172 THOMAS JOHNSON DRIVE
SUITE 204
FREDERICK, MD 21702
TELEPHONE: 301-663-8343
FAX: 301-695-0746

PATIENT REGISTRATION FORM *(Please complete all information)*

PSYCHIATRY CENTER OF FREDERICK

TODAY'S DATE: ❑ **SELF PAY** ❑ **INSURED**

PROVIDER OF SERVICE: ❑ Dr. Allan L. Levy ❑ Wendy Levy, LCPC ❑ Gail Click, LCSW

PATIENT INFORMATION

PATIENT'S LAST NAME: **FIRST:** **MIDDLE:** ❑ Mr. ❑ Miss. ❑ Mrs. ❑ Ms. **MARITAL STATUS:** (check one) ❑ Single ❑ Married ❑ Div ❑ Sep ❑ Widow

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name? **SOCIAL SECURITY NUMBER:** **BIRTH DATE:** / / **AGE:** **SEX:** ❑ M ❑ F

STREET ADDRESS: **HOME PHONE:** ( ) **CELL PHONE:** ( )

P.O. BOX: **CITY:** **STATE:** **ZIP CODE:**

OCCUPATION: **EMPLOYER:** **EMPLOYER PHONE NUMBER:**

PRIMARY CARE PHYSICIAN: **PHONE NUMBER:**

SPOUSE'S NAME: **SPOUSE DOB:** **PHONE NUMBER:**

PATIENT'S NAME (IF MINOR): **PHONE NUMBER:**

PRIMARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

INSURANCE NAME:

POLICY HOLDER'S NAME: **MEMBER ID:** **GROUP #:**

POLICY HOLDER'S SS#: **POLICY HOLDER'S DOB:**

POLICY HOLDER'S EMPLOYER:

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ❑ Self ❑ Spouse ❑ Child ❑ Other

NAME OF SECONDARY INSURANCE (if applicable): **SUBSCRIBER'S NAME:** **POLICY #:** **GROUP #:**

PRIMARY INSURANCE INFORMATION

I understand that Dr. Allan L. Levy does not complete disability evaluations for long term disability but will complete forms for short term disability by appointment ONLY.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to ALLAN LEVY, MD, PC. I understand that I am financially responsible for any balance not covered by insurance. I also authorize Allan L. Levy MD, PC or insurance company to release any information required to process my claims. I understand that filing a claim with my insurance company or other third party payor does not relieve me from my responsibility for the payment of all charges, I further acknowledge that I am responsible for the payment of all charges for services rendered by Dr. Allan L. Levy's practice to me or the patient indicated. By signing this document I will guarantee the payment of these charges for medical services rendered.

PATIENT/GUARDIAN SIGNATURE: **DATE:**

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TREATMENT CONSENT FORM *(Please complete all information)*

PSYCHIATRY CENTER OF FREDERICK

CONSENT TO THE USE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATION

PSYCHIATRIC SERVICES
Gail L. Glick, LCSW

PASTORAL COUNSELING
Dr. Wendy A. Levy, Executive Director

I understand that as part of my healthcare, Dr. Allan L. Levy/Psychiatry Center of Frederick originates and maintain health records describing my health history, symptoms, examination and lab results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communications among the many healthcare professionals who contributes to my care
- A source of information for applying my diagnosis and procedural information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to see and obtain copies of my medical record upon written request during normal business hours and a designated time set by Dr. Allan Levy/Psychiatry Center of Frederick. I understand that I have the right to request amendments be made to my medical record. All amendments need to be written on separate sheet of paper and duly indicated “amendment to the record”. I understand that a five-year history of all disclosures will be accessible to me including the purpose of the disclosure and the address of the recipient. I may receive a copy of this history within 60 days of my written request and I understand that I may have to pay a reasonable charge for any copies. I understand that I have the right to request restrictions as to how my health information may be used or disclose to carry out treatment, payment or healthcare operations and that the practice is not required to agree to restrictions requested. If Dr. Allan Levy/Psychiatry Center of Frederick does agree to any restriction, the agreement is binding on use. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I hereby consent to the use and disclosure of my individual identifiable health information for treatment, payment and healthcare operation purposes

_____

Patient’s Name (please print)

_____

Signature of Patient or Legal Representative Date

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PATIENT FINANCIAL POLICY FORM

(Please complete all information)

PSYCHIATRY CENTER OF FREDERICK

Patient Name: _____ **Date of Birth:** _____

We are privileged you have chosen us as your health care provider. We are committed to providing you with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to treatment. If you have any questions, please feel free to ask us before signing this form. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

FULL PAYMENT IS DUE AT TIME OF SERVICE. We accept cash, checks, and most major credit cards. There will be a $25.00 fee on all returned checks.

REGARDING INSURANCE

It is the responsibility of the insured to know what their eligibility and coverage is with their insurance carrier. Although we will verify your coverage and calculate your deductible and copayments as accurately as possible, please understand that all treatment plans given are only an estimate based on the information your insurance company provides. ***All deductibles, co-insurance, co-payments and non-covered services*** are due the day the treatment is rendered. It is the insurance company that makes the final determination of your financial obligations and eligibility for services. You agree to pay any portion not covered by your insurance. Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. ***If you have not met your deductible*** — you may receive a statement with additional balances after your claim has been processed by your insurance.

REFERRALS AND PREAUTHORIZATION

If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

SELF-PAY PATIENT

If you are a self-pay patient payment in full is due at the time of your service.

MISSED APPOINTMENT/LATE CANCELLATION

In the event that you cannot keep your appointments, 24 hours notice is required to avoid a “No Show” fee of $40.00 charged to your account for established patient and $50.00 for new patient appointment.

WORKERS’ COMPENSATION

In the case of a workers’ compensation, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.

I have read and understand the above Financial Policy.
By signing below, I acknowledge responsibility and agree to the terms above.

_____ _____

Signature of Patient/ Responsible Party Date

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PATIENT COMMUNICATION CONSENT FORM *(Please complete all information)*

PSYCHIATRY CENTER OF FREDERICK

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal Law. The administrative simplification section of this Act is of concern to our practice and requires us to comply with specific rules regarding:

- **Unique Identifiers for health plans, providers, individuals and employers**
- **Healthcare transactions and code sets for transmitting electronic data**
- **Privacy regulations over disclosure and use of health information**
- **Security regulations over protection of electronic health information**

All of these rules have been developed by the Department of Health and Human Services and will become final in a staged manner.

It is our ***policy*** not to release any confidential and /or unauthorized information by home telephone, work telephone, answering machine, voicemails, cellular phone, email or fax. When returning telephone calls we will not leave a message if the name or telephone number is not on the recorded message to identify the patient or responsible party. Information will not be left with any unauthorized person who may answer the phone if their name is not listed on this form.

If you would like to have your medical information released and appointment scheduled or confirmed to someone other than yourself please complete following:

I _____ authorize Psychiatry Center of Frederick/Dr. Allan L. Levy to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

****PLEASE NOTE: If nothing is checked, we will assume permission is NOT given ***

Psychiatry Center of Frederick/Dr. Allan L. Levy can contact me anywhere reasonably necessary for medical care.

Home Number:_____ ❑YES ❑NO

Cellular Number: _____ ❑YES ❑NO

Work Number: _____ ❑YES ❑NO

Answering Machine/Voice Mail:_____ ❑YES ❑NO

Please list name of Individual that we can release information to and also can schedule/confirmed your appointment:

Spouse: _____ ❑YES ❑NO

Parents:_____ ❑YES ❑NO

Brother/Sister: _____ ❑YES ❑NO

Son/Daughter: _____ ❑YES ❑NO

Other (specify):_____ ❑YES ❑NO

_____ _____

Patient/Guardian Signature Date

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PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT *(Please complete all information)*

PSYCHIATRY CENTER OF FREDERICK

* You May Refuse to Sign This Acknowledgement*

By signing this form, you acknowledge receipt of Notice of Privacy Practice of Psychiatry Center of Frederick. Our Notice of Privacy Practices provides information about how we may use and disclose your Protected Health Information; we encourage you to read entirely before signing.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at 301-663-8343

I,_____, have received a copy of t Notice of Privacy Practices for Psychiatry Center of Frederick (Dr. Allan L. Levy).

_____
Please Print Name

_____
Signature of patient (**Parent signature if minor**) Date

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____
_____
_____
_____
_____

Signature of Provider Representative: _____ Date:_____

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NOTICE OF PRIVACY PRACTICES *(Please complete all information)*

PSYCHIATRY CENTER OF FREDERICK

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

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protect medical information about you. We create a record of the care and services you receive at Psychiatry Center of Frederick. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by law to make sure that medical information that identifies you is kept private, to make available to you this notice of our legal duties and privacy practices with respect to medical information about you, and to follow the terms of the notice that is currently in effect.

Your Authorization. Except as outlined below, we will not use or disclose your protected health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization

Uses and Disclosures for Treatment and Payment. We will make uses and disclosures of your protected health information as necessary for your treatment. We may use protected health information, to converse or by written means with pharmacies or pharmaceutical companies that may be of interest to the individual patient. We will make uses and disclosures of your protected health information as necessary for the purpose of payment and those health professionals that have treated you or provided services to you

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your protected health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care.

Appointments. We may contact you to provide appointment reminders for your follow-up visit, if you wish appointment reminders to not be left on voicemail; you may request such confidential communication in writing or call our office to notify us about that.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization. An example would be for public health requirements, court order or to report child abuse.

RIGHTS THAT YOU HAVE

Access to your Protected Health Information. You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you a fee that is consistent with state law if you request a copy of the information

Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on certain uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate.

Any person /patient may file a complaint to the practice and to the secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Business Office at the following phone number -301-663-8343. All complaints will be addressed and results will be reported to the Corporate Compliance Office and Managing Partners.

It is Psychiatry Center of Frederick (Dr. Allan L. Levy) policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

PLEASE RETAIN THIS COPY FOR YOUR RECORDS