LONG ISLAND
behavioral
medicine
www.LongIslandBehavioralMedicine.com

PATIENT INFORMATION SHEET

Please complete both sides of this form. When finished, sign the attestation at the bottom of the page and return to the front desk.

PATIENT INFORMATION

NAME ____________________ DATE OF BIRTH__________ SEX M / F

ADDRESS ____________________ APT #__________

CITY ____________ STATE ______ ZIP CODE ______ S.S. #__________

Preferred Phone (Home/Cell) __________ Secondary Phone (Home/Cell)__________

Employer / School ____________________ Phone__________

Referring Doctor/Therapist____________________ Phone__________

Primary Care Physician ____________________ Phone__________

EMERGENCY CONTACTS (Please list at least one):

Name ____________ Phone __________ Relationship __________

Name ____________ Phone __________ Relationship __________

Please complete this section if the patient is under 18 years of age:

PARENT/GUARDIAN NAME ____________________ RELATIONSHIP __________

ADDRESS (if different from patient) ____________________

CITY ____________ STATE ______ ZIP CODE ______

Preferred Phone (Home/Cell) __________ Secondary Phone (Home/Cell)__________

Pharmacy name, address and phone number: ____________________

***Per New York State law, all prescriptions must be sent to your pharmacy electronically.**
****Patients must contact this office directly with any requests for new prescriptions or refills.**
This office does not accept automated prescription requests from pharmacies.

Preferred Medical Lab: Quest Diagnostics Sunrise Medical Labs LabCorp Other: __________

If you answer "YES" to any of the following questions, please explain in the space provided.
Is your condition related to:

A Work-Related Accident? YES NO ____________________

An Automobile Accident? YES NO ____________________

Any other Accident? YES NO ____________________

Are you currently under the care of a Mental Health provider? YES / NO ____________________

Are you currently prescribed any medications for a Mental Health condition? YES / NO ____________________

____

Do you have any current or chronic medical conditions? YES / NO ____________________

____

Do you have any allergies to any medications? YES / NO ____________________

Please list any medications you are currently taking (prescribed OR "over the counter") ____________________

____

****PLEASE COMPLETE REVERSE SIDE OF THIS SHEET****

BILLING INFORMATION

This office does not participate in any insurance plans. This office does not bill or accept payment from any third parties including, but not limited to, any private health insurance plans, Medicare, Medicaid, or Worker's Compensation. Payment in full is due at the time of service. Accepted forms of payment include: Cash, Check, Debit/Credit Card (Visa, MasterCard, & Discover)

If you have "*Out of Network Mental Health Benefits*" included in your insurance plan, please notify a member of our billing staff and we will gladly provide you with an insurance form that you may submit to your plan. Please note, *we cannot provide an insurance form for a service until it has been paid in full*.

****MEDICARE ELIGIBLE PATIENTS: As of January 1, 2015, this office has opted out of Medicare**. If you are Medicare-eligible, or become Medicare-eligible during the course of your treatment, you must sign a "Medicare Private Contract" prior to receiving treatment. If you currently are Medicare-eligible, or if you become Medicare-eligible, you must inform your treatment provider or a member of the office staff immediately.

Although we do not participate in any insurance plans, please complete this section and provide our staff with your insurance card(s). A copy will be kept in your file as this information is necessary for any prior authorizations that may be required for medication, treatment, or testing.

Primary Insurance ______________________________ ID # ______________________ Group # ___________________

Please complete this section only if the patient is NOT the primary insured:

Insured's ID # ______________________ Insured's Name ______________________________________ Sex: M / F

Telephone _________________ Insured's DOB ________ Relationship to Patient: Spouse / Child / Dependent / Other

Insured's Address _____________________________________ City ________________ State ________ ZIP __________

Secondary Insurance ____________________________ ID # ______________________ Group # ___________________

Please complete this section only if the patient is NOT the primary insured:

Insured's ID # ______________________ Insured's Name ______________________________________ Sex: M / F

Telephone _________________ Insured's DOB ________ Relationship to Patient: Spouse / Child / Dependent / Other

Insured's Address _____________________________________ City ________________ State ________ ZIP __________

You must notify this office immediately of any changes to your insurance coverage or eligibility.

Cancellation Policy

If you are unable to make a scheduled appointment, you must contact the office immediately. Appointments must be cancelled or rescheduled at least 24 hours prior to the scheduled appointment time. Any changes to an appointment made within 24 hours of the scheduled appointment time will be considered a "Late Cancellation."

If you arrive late for an appointment, you *MAY* be seen for the remaining time left in your scheduled appointment and you will be responsible for paying the full fee for the scheduled visit.

If you arrive after your scheduled appointment time has ended, it will be considered a "Missed Appointment" and you will be charged accordingly.

THE CHARGE FOR ALL LATE CANCELLATIONS, OR MISSED APPOINTMENTS WILL BE THE FULL FEE FOR THE SCHEDULED VISIT.

All information I have provided on this form is true and complete. I agree to inform LIBM, PC of any changes to my medical history, insurance information or eligibility, personal information, or if I move.

Patient's Name _________________________________ Signature _________________________ Date _______________

(Patient must sign if over 18)

If patient is under 18

Parent/Guardian Name ___________________________ Signature _________________________ Date _______________