REGISTRATION

Marnin E. Fischbach, M.D., P.C.

Date _____ Email address: _____

Last Name _____ First _____MI _____

Address _____ City _____State _____ ZIP _____

Cell Phone (__)_____Home Phone (___)_____ Work Phone (___)_____

Date of Birth _____ Age _____ SSN# _____Marital Status _____

Employer _____Occupation _____ Address _____

Whom may we thank for referring you? _____

Policy Holder Insurance Information

Insurance ID Number _____ Insurance Company Name _____

Policy Holder Name _____ Relationship to Patient _____

Policy Holder Address_____ City _____ State_____ Zip _____

Policy Holder Address Phone Number _____DOB _____SSN#_____

Group # _____ Insurance Address _____ Insurance Phone Number _____

Policy Holder Employer Name _____

Employer Address_____ Occupation _____

City _____ State _____ Zip _____

You are responsible for providing our office with the most current information. All balances from incorrect information will be billed to you.

Secondary Insurance _____

Address _____

ID# _____ Group # _____

Name of Insured _____Relationship to Patient _____

Primary Care Physician

Name _____ Phone ( ) _____

Outside(Emergency) Contact: Name _____Phone_____Relationship_____

Insurance Authorization and Assignment: I request the payment of authorized benefits be made in my behalf to Marnin E. Fischbach, M.D. P.C. for any services furnished me by that physician. I authorize release of any medical information necessary to process my claim. I understand that I am responsible for all charges regardless of insurance coverage. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. I have reviewed the Notice of Privacy Practices which describes how my health information may be used or disclosed, and affirm that this is clear to me and I understand all of it.

Signature_____Date _____

Revised 12/21

Marnin E. Fischbach, M.D., P.C.
Agreement and Consent for Psychiatric Evaluation and Treatment

Client Name _____

I understand that by signing this Agreement I am entering into a contract for Dr. Fischbach to provide professional individual concierge services to me or my child under the following terms and acknowledgements:

1) I will provide the clinical information requested by Dr. Fischbach and/or staff so that he may make appropriate assessments and recommendations.

2) I will work with Dr. Fischbach to determine a mutually agreeable Treatment Plan and discuss any concerns or questions I have regarding these professional or administrative services.

3) I understand that no promises have been made to me as to the results of treatment of any procedures provided by Dr. Fischbach.

4) I will respect my commitment to follow up appointments and keep the appointments that I have scheduled. If I am unable to keep an appointment I will give notice of a minimum of **TWO BUSINESS DAYS**. If I do not, I will be responsible for a cancellation fee of $70.00 for medication appointments and $200.00 for psychotherapy appointments. I authorize Dr. Fischbach to bill these as well as regular appointment charges directly through any electronic, bank, or credit card account.

5) All other services not covered by insurance will be billed at the hourly rate of $400.00 per hour, including but not limited to medication precertifications, records review, report / form preparation , faxing/copying, duplication, and telephone consultations.

6) I understand that my copays or self-pay responsibilities will be made at the time of service. I understand that I may not be treated at my appointment if payments cannot be made at that time, or if I have an unpaid balance due.

7) I understand that I may stop my treatment at any time. I agree to give Dr. Fischbach notice of this decision. I will still be financially responsible for services I have already received.

8) I agree that if I need a prescription called in due to my canceling or missing an appointment, loss of prescription, etc. I, not my insurance company, will be responsible for a minimum $20 fee.

9) I will keep Dr. Fischbach and/or staff informed of current information regarding my address, telephone numbers and insurance coverage.

10) I acknowledge that while insurance may cover part or all of the fees charged by Dr. Fischbach, I am ultimately responsible for the cost of the services provided.

11) I understand that the fees for office services do not include the cost of telephone calls to reorder medication, send reports, preauthorize medications, etc, or to provide other professional services and I agree to be responsible for the cost of these services.

12) I authorize use of text and phone messaging for efficient communication with Dr. Fischbach.

13) My Primary Care Physician, Doctor _____ Phone # _____ is responsible for my medical care (or the medical care of my child).

14) My psychological treatment is under the care of _____ whose phone number is _____

I authorize Dr. Fischbach and/or staff (Please check all applicable authorizations)

____ To exchange or release any applicable information with my Primary Care Physician _____Not to release information to my Primary Care Physician

____ To exchange or release any applicable information with my Psychotherapist _____Not to release information to my Psychotherapist

15) Dr. Fischbach and/or staff may leave messages regarding appointments on my home cell answering machine or via text message.

16) I accept the statement of Rights & Responsibilities and the Service Brochure.

17) I understand that if my account becomes delinquent, interest charges of 1 ½ % per month will be assessed and the account could be sent to collections.

18) I understand that medications will not be refilled by telephone, off-hours, or on weekends except under emergency circumstances.

Signed _____ Date _____

Client or person authorized to sign for client. Before you sign, please note any exceptions to the above consent statements.

Revised 12/21

Marnin E. Fischbach, M.D., P.C.
Notice of Privacy Practices

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 commitment to your privacy:

This practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private.

We will use the information about your health, which we get from you or from others, to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you read this NPP, we will ask you to sign an Authorization Form to let us use and share your information.

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private, but there are some circumstances when the laws require us to use or share it. For example:

1) When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person/organization that is able to help prevent or reduce the threat, or the person who is in danger.

2) Court orders, some lawsuits and legal or court proceedings.

3) If a law enforcement official requires us to do so.

I understand that I can revoke or cancel this authorization at any time by sending a signed letter to Dr. Fischbach at his address. If I do this, it will prevent any releases after the date it is received, but not change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Fischbach, nor will it affect my eligibility for benefits.

I understand that I may inspect and have a copy of the health information described in this authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may no longer protected by those regulations.

I affirm that everything in this form is clear to me, and I understand all of it.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the Client

_____
Description of personal representative's authority

2) I, a mental health professional, have discussed the issues with the client and his or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willingly consent.

_____ _____ _____
Signature of professional Printed name of professional Date

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