Jersey Forensic Consulting LLC

VIVIAN CHERN SHNAIDMAN M.D.

DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY AND FORENSIC PSYCHIATRY

475 Wall Street, Princeton, NJ 08540

New Patient Form - Please submit via fax (609 964 1700) or email (info@shnaidman.com)

Last Name:	First name:	Middle Initial:
Today's Date: / /	SSN#:	
Age:	Legal Gender:	Date of birth: / /
Marital status:	Occupation:	Employer:
Current address:		
City:	State:	ZIP Code:
Email:		Receive appointment reminders via email? Yes No
		Receive details regarding treatments via email? Yes No
Mobile Phone:		May we leave detailed messages on this phone? Yes No
Home Phone:		May we leave detailed messages on this phone? Yes No
Alternative Phone:		May we leave detailed messages on this phone? Yes No

PRIMARY INSURANCE COMPANY: PLEASE WRITE THE NAME OF YOUR INSURANCE COMPANY HERE! (EX AETNA, BC/BS ETC.) WE DO NOT ACCEPT ALL INSURANCES!!!

PATIENT ID#:		GROUP #:
Subscriber's Name:		Subscriber's DOB: / /
Relationship to Insured Patient:		
Subscriber's Address:		
City:	State:	ZIP Code:
INSURANCE CO. PHONE:		
INSURANCE CO. ADDRESS:		

SECONDARY INSURANCE COMPANY: Name:		
PATIENT ID#:		GROUP #:
Subscriber's Name:		Subscriber's DOB: / /
Relationship to Insured Patient:		
Subscriber's Address:		
City:	State:	ZIP Code:
INSURANCE CO. PHONE:		
INSURANCE CO. ADDRESS:		

RESPONSIBLE PERSON: (Is this information the same as the patient? Yes No If yes, you may skip this section)		
Name:		
Current Address:		
City:	State:	ZIP Code:
Relationship to Patient:		
EMERGENCY CONTACT:		
Name:		
Phone:		Relationship to Patient:
PRIMARY CARE PHYSICIAN:		
Phone:		
REFERRING PROVIDER:		
If none, how did you hear about us?		
□ A friend □ Facebook □ Psychology Today □ Internet		
□ Other (provide details)		

THERAPIST:	
Phone:	Date of last visit:
WHY ARE YOU SEEKING TREATMENT NOW? describe	
MEDICAL HISTORY:	
List any medical problems:	

List any hospitalizations (including Psychiatric or Substance Abuse):

Please list all medications (prescribed or over the counter):				
Name of Medicine	**Dose**	**Reason prescribed**	**Prescribed by**	**Date started**

Food or Drug Allergies:

PSYCHIATRIC HISTORY: Please circle either “No” or “Yes” to the following questions.

Have you ever been given a psychiatric diagnosis? Yes No If yes, please describe below.

Have you ever had psychotherapy or counseling in the past? Yes No If yes, please describe below.

Have you ever seen a psychiatrist before? Yes No If yes, please describe below.

Have you ever attempted suicide or had suicidal thoughts? Yes No If yes, please describe below.

Have you ever been the victim of mental, physical, or sexual abuse? Yes No If yes, please describe below.

Have you ever had a problem with alcohol or drugs? Yes No If yes, please describe below.

How often do you:

Smoke	Never O	Monthly O	Weekly O	Daily O
Drink Alcohol	Never O	Monthly O	Weekly O	Daily O
Use Drugs	Never O	Monthly O	Weekly O	Daily O

WHAT ARE YOUR GOALS FOR TREATMENT?

FAMILY HISTORY:
Mental Illness? Yes No If yes, who, describe:
SubstanceAbuse? Yes No If yes, who, describe:
Suicide? Yes No If yes, who, describe:

Credit Card

Everyone must fill in this section. This information is reserved for unresolved charges as described below.

Name on Card:		
Card Number:	Expiration Date:	
Billing Phone:	Code:	
Billing Address:		
City:	State:	ZIP Code:

AGREEMENT

CONFIDENTIALITY

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult,
2. When the patient presents an imminent danger to self,
3. When the patient presents an imminent danger to others,
4. If a judge determines that our discussions are not confidential, a judge may request specific information.

If the patient is a minor, you acknowledge that your child's records are confidential except in the above stated exceptions. Please be aware that submitting mental health claims to your insurance company carries a certain amount of risk to confidentiality, privacy, and the future ability to obtain health or life insurance, or even a job.

INSURANCE

Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Please be aware that not all issues/problems/conditions dealt with in therapy are covered by insurance. It is your responsibility to verify the specifics of your coverage.

We currently submit claims on your behalf if you have **Medicare, Aetna, and United Healthcare. Aetna and United Healthcare are outsourced to a company called HEADWAY and you must fill out their forms in order for billing to be submitted on your behalf**. If you have another insurance, you are welcome to see Dr. Shnaidman for treatment, and we will provide you with a bill to submit to your insurance company after you have paid the appointment fees. This may be useful for patients with out-of-network benefits. You are responsible for any applicable deductibles and copays at the beginning of each session. For prospective patients with Blue Cross Blue Shield who would like to use their out-of-network benefits (if you have any), we may be able to send your claims on your behalf, as a courtesy. This does NOT guarantee payment to us or you. This also does not guarantee coverage for treatment and you may be responsible for services rendered which your insurance does not cover. If you would like to proceed with using your out-of-network benefits, you must complete and sign our individual Financial Agreement for BCBS patients. You understand that insurance is billed as a courtesy to you and that **you are responsible for full payment if the insurance company denies the claim.**

You also understand that we may stop accepting your insurance in the future, however we will notify you before this change goes into effect.

CANCELLATION

Cancellation of an Appointment:

Please be courteous by calling Dr. Shnaidman's office promptly if you are unable to show up for an appointment, in order to be respectful of the needs of other patients. We require that you call at least 24 hours in advance to cancel. In the event of a failure to give a **24-hour notice** of a cancellation, **you will be charged a $100 fee**. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care. _____initial here

How to Cancel Your Appointment:

To cancel your appointment, please call 609-910-1715. If you do not reach the receptionist, you may leave a detailed message on our voicemail or send an email to info@shnaidman.com. If you would like to reschedule your appointment, please be sure to leave your name and phone number. We will return your call promptly. Patients will be held responsible for a LATE CANCELLATION fee of **$100** if a scheduled appointment is not canceled within 24 hours. There will be NO EXCEPTIONS. If there are more than two consecutive late cancellations, the balance must be paid before a new appointment is scheduled. **Please be advised that habitually missed, canceled, late, or no show appointments, are subject to result in discharge from the practice due to non-compliance._____initial here**

No-show Appointment:

A “no-show” is when a patient misses an appointment without canceling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient’s chart as a “no-show.” If you are more than 15 minutes late, you are subject to wait, or you can reschedule for later in the day if there is availability. Patients will be held responsible for a NO-SHOW fee if an appointment is missed. There will be NO EXCEPTIONS. The fee for a No-Show will be **$100.00**, which MUST be paid before the patient can schedule a new appointment._____initial here

NEW PATIENT NO-SHOW POLICY

Credit card information must be filled out on this new patient form, in the event that there is a no-show for the first appointment you will be responsible for the entire cost of the no-show first appointment ($450) before you will be rescheduled. **_____initial here**

FEES

Fees are listed below for the initial assessment and for individual therapy. Letter writing, consultations with other professionals, telephone conversations, reading records or reports, travel time, longer sessions, etc. will be billed at a rate determined to fit the need. This agreement supersedes all previously agreed to financial agreements and is effective as of the date signed. If your account is overdue (unpaid) and there is no written agreement for a payment plan, I can use legal or other means (court, collection agencies, etc.) to obtain payment. _____initial here

Patient Fee Schedule

You will be responsible for the following charges, at the time of service unless other arrangements have been made. Please note that this represents the special out-of-network cash price. Your insurance will be billed according to CPT-guidelines for ALL covered services.

Initial evaluation and diagnostic inventory	$450.00
Follow-up + psychotherapy (45 min)	$350.00
Follow-up (15 min)	$225.00
Medication management (15-20 min.)	$225.00
Missed appointment or Late cancellation (less than 24 hour notice)	$100.00
Returned payments / bounced checks	$50.00
Letters (minimum fee)	$100.00
Cognitive Testing	$175.00

Refill Policy:

Once a patient and doctor have reached a point in treatment where the patient is stable, you may qualify for refills on controlled substances without coming in for an appointment. In this case, the patient must notify our office within 5 business days of the anticipated date of running out of medication. In the state of NJ, most controlled substances can only be prescribed for 30 days, under the law. We reserve the right to require monthly in-person appointments for any patient who misuses our policy of courtesy refills. _____initial here

FINANCIAL POLICY :

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. **This includes applicable coinsurance and copayments for participating insurance companies. Dr. Vivian Shnaidman** accepts cash,credit cards, Paypal, & personal checks. There is a service charge for returned checks. We also have been granted the legal right to add a 4% service charge to credit card payments. We reserve the right to institute this policy at any time _____initial here

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality. In such circumstances, we may advise you to seek treatment with a clinic or hospital clinic in your area. _____initial here

INSURANCE:

We bill appointments to participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments- coinsurance at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. _____initial here

If you need assistance or have questions, please contact our office between 10:00 am and 5:00 pm, Monday through Friday at 609-910-1715 or email us at info@shnaidman.com

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Excessive abuse of scheduled appointments may result in discharge from the practice. _____initial here

I have read and understand **Dr. Shnaidman** Financial Policy. I agree to assign insurance benefits to **Dr. Shnaidman's** Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for the cost of collections. _____initial here

You will be charged $100.00 for every
missed or canceled appointment without 24 hours notice.

If habitually miss or cancel appointments, we have the right to discharge you for non-compliance with treatment.
Initial Here:____

By signing here you acknowledge that you have read and understand "Financial Policy".

Signature:	Date:

FINANCIAL AGREEMENT FOR BLUE CROSS BLUE SHIELD OUT-OF-NETWORK PATIENTS
Options: (Please circle the option you would like to choose)

1. The first option is to choose to use your OON benefits and then give us the reimbursement checks AFTER you have met your deductible. Until the deductible is met, you would pay the full allowed amount (allowed rate for Horizon BCBS) for the appointment. After the deductible is met, you would pay the co-insurance or co-pay for each follow-up appointment, which is what your OON benefits includes after your deductible is met. If using this option, all reimbursement checks sent from BCBS to the patient (you) AFTER the deductible is met, **must be given to Dr. Shnaidman and signed off on the back of the check to be paid to her.** You can also keep the check and pay that exact check amount on your next appointment, in addition to your normal co-pay or co-insurance. In some rare cases we will be paid for the reimbursement, and if this is the case, you are NOT responsible for paying back that amount. This can all be verified through the EOBs from your insurance. IF YOU DO NOT FORWARD THE OWED MONEY BUT INSTEAD CHOOSE TO KEEP IT, YOU ARE BREAKING THE LAW. NOT ONLY WILL YOU BE DISCHARGED BUT CRIMINAL CHARGES MAY BE BROUGHT AGAINST YOU. **Initial here _____**

2. The second option is to always pay the full allowed amount for the appointment, and whenever your deductible is met, you would just keep the reimbursement checks you receive. In summary, you are just **not going to use the option of applying a co-insurance or co-pay after meeting your deductible**, since you would keep the check after meeting it anyway. **What you are paying out of pocket turns out the same for both options. Only the method is different. Initial Here _____**

3. The third option is to not go through your insurance at all and just pay the self pay rate for appointments. The special reduced self-pay new patient appointment rate is $450 and follow-up appointments are $225. **Initial Here_____**

Disclaimer: we have found with BCBS, that patient co-insurances tend to vary as per the EOB(explanation of benefits). We charge patients the exact amount shown on the benefits information when we initially verify insurance coverage. As a result,, patients may not be paying their full responsibility or may be over/under paying at their appointments. We check EOBs as soon as they are available and do our best to notify patients immediately of any balances that they owe or we owe them, but please be advised that you are responsible for any unpaid amounts.

I fully acknowledge and understand the given options stated above. I also agree to pay the full amount I am liable for, based on the option I chose above, which is Option_____

Relationship to Patient: _____

Signature:_____Date: _____

The first appointment must be in person Initial here _____

If you are prescribed any controlled substance then you must come to the office for an in-person visit at minimum once per year. Initial here _____

All patients must see the doctor for a face-to-face appointment if a patient needs to request a change in medication or medication dosage, discontinuing a medication, adding a medication, or going back to an old medication. Any and all medication changes must be discussed during an in-person appointment. **Initial here _____**

Patients cannot email Dr. Shnaidman at her personal email address. All communications related to patient care **must be sent to info@shnaidman.com .** This is to **maintain HIPAA compliance and privacy. Dr. Shnaidman reserves the right to ignore emails sent to her personal or direct email address and delete them in order to remain HIPAA compliant**

Initial here_____

MISCELLANEOUS PROVISIONS

HEADINGS FOR REFERENCE ONLY: The headings preceding the text of the several sections of this Agreement are inserted for convenience and shall not affect the meaning, construction, scope or effect of this Agreement.

CONSTRUCTION OF AGREEMENT

If any provision of this Agreement is held to be invalid or unenforceable, all other provisions shall nevertheless continue in full force and effect.
This Agreement shall be construed and governed in all respects in accordance with the laws of the State of New Jersey.

MODIFICATION

A modification or waiver of any of the provisions of this Agreement shall be effective only if made in writing and executed with the same formality as this Agreement. The failure of either party to insist upon strict performance of any of the provisions of this Agreement shall not be construed as a waiver of any subsequent default of the same or similar nature.

CONSENT TO EXCHANGE OF INFORMATION FOR TREATMENT AND PAYMENT PURPOSES

I authorize the release and exchange of information between my therapist and the referral source and other co-treating providers for the purpose of treatment, and payment. I also authorize the release of information to my health plan for claims or other health plan purposes. Your signature below indicates that you give Dr. Shnaidman your consent for treatment.

Patient's Signature:	Date:
Patient's Printed Name:	Date:
Responsible Party's Signature: (if applicable)	Date:
Responsible Party's Printed Name: (if applicable)	Date:

Notice of Privacy Practices

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

I want you to know that I respect the privacy of your personal medical records and will do all I can to secure and protect that privacy. I strive to always take reasonable precautions to protect your privacy. When appropriate, I provide the minimum necessary information to only those I feel are in need of your health care information. This includes information about treatment, payment, and/or health care operations in order to provide health care that is in your best interest.

I also want you to know that I support appropriate access to medical records. With your consent, I may disclose personal health information for purposes of treatment, payment, or health care operations such as communication with hospitals, co-treaters, and health plans.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, if you refuse to disclose your personal health information, I have the right to refuse to treat you. If you choose to give consent in this document, at some future time you may request to refuse to disclose all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You may request a restriction on any authorization to disclose personal health information. I am not required to agree with this restriction request. You have the right to have me amend your protected health information. If the request is denied, you may file a disagreement with me and prepare a rebuttal, which will be added to your personal health information. You have a right to receive an accounting of disclosures of your health information I have made, except that I do not have to account for the disclosures provided to you or pursuant to your written authorization, or as described herein regarding treatment, payment, health care operations, notification and communication with family, and specialized government functions, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

We will not use or disclose your therapy notes without your prior written authorization except for the following: use by the originator of the notes for your treatment, for training our staff, students and other trainees, to defend ourselves if you sue us or bring some other legal proceeding, if the law requires us to disclose the information, in response to health oversight activities concerning your therapist, to avert a serious and imminent threat to health or safety, or to the coroner or medical examiner as appropriate.

I want you to know that I continually undergo training to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule.” I strive to achieve the very highest standards of ethics and integrity in providing services to my patients.

If you have any questions or problems, please speak with me directly, as I welcome your feedback. You may also file a complaint with the Secretary of Health and Human Services if you believe that I have violated your privacy rights.

By signing here, you acknowledge that you have received a copy of the “Notice of PrivacyPractices”.

Signature:	Date:

Please fill this out if you would like us to contact your therapist, family member, etc.
Please note that HIPAA (The Health Insurance Portability and Accountability Act) permits communication between healthcare providers who are treating a mutual patient. We provide this form as an added courtesy.

If you are an adult who would like to share information with your parent or child, or other adult, please fill out this form.

At the request of the individual, I _____, , hereby authorize the release andre disclosure, via paper, email, fax, or verbal/telephone communication, of any and

___all medical, psychiatric, and psychological records;

___any drug and alcohol abuse treatment information; and

___any HIV/AIDS information kept by:

Vivian Chern Shnaidman M.D.
475 Wall Street
Princeton, NJ 08540
Phone: 609-910-1715
Fax: 609-964-1700

To:

Phone:

Fax:

Name (Print) _____ Signature _____Date_____

Witness Name (Print) _____Signature_____Date_____

Parent or Legal Guardian (Print)_____ Signature_____

Date _____

Authorization is subject to revocation at any time by the patient unless the provider has already relied upon it. Authorization will expire in accordance with our record retention policy. For activities covered by HIPAA, I do not condition treatment, payment, enrollment, or eligibility for benefits on this authorization.