Lake Mary Psychiatry and Counseling, LLC

Jeffrey Krotenberg, D.O.
305 Waymont Court, Suite 111
Lake Mary, FL 32746

Date:_______________

Patient Information (Please print)

Patient Name:____
First MI Last

Address:____

City:________________________________ State: _________________________ ZIP: _____________________

Home Phone: (____) _______________ Work Phone: (____)_______________ Cell Phone: (____)_____________

Date of Birth:___________________ Social Security No.:____

Employer:____

Married ( ) Single ( ) Divorce ( ) Widowed ( )

Race: (check one): ( ) Caucasian ( ) African American ( ) Asian
( ) American or Alaskan Indian ( ) Native Hawaiian or Other Pacific Islander
( ) Other ( ) Decline to answer

Ethnicity:
(check one); ( ) Hispanic or Latino ( ) Non Hispanic or Latino ( ) Other
( ) Decline to answer

EMERGENCY CONTACT:

Name:____ Relationship:_________________________

Address:____ Home or Cell Phone:___________________

If patient is not responsible for payment, please complete Guarantor Information:

Guarantor:____
First MI Last

Relation to Patient:____

Address:____

Home Phone: (____) _______________ Work Phone: (____)_______________ Cell Phone: (____)_____________

Date of Birth:___________________ Social Security No.:____

Insurance Information (Please complete the information that applies to the patient)

Primary Insurance:____ Effective Date:________________

Address:____

Policy Number:_______________________________ Group No.:_________________ Phone No.:_________

Subscriber: _________________________________ Relationship to patient:___________________________

Subscriber Social Security No.:___________________________ Subscriber's Date of Birth_______________

Subscriber's Employer:____

Secondary Insurance:____ Effective Date:________________

Address:____

Policy Number:_______________________________ Group No.:_________________ Phone No.:_________

Subscriber: _________________________________ Relationship to patient:___________________________

Subscriber Social Security No.:___________________________ Subscriber's Date of Birth_______________

Subscriber's Employer:____

Patient Health History

Name:____
Date:____

Age:______________________________ **Weight:**___________________________________
Height:____

	Yes	No	Suspected	Date First Occurred
Poliomyelitis				
Nephritis				
Tuberculosis				
Bronchitis				
Rheumatic Fever				
Chorea				
Venereal Disease				
Cancer				
Coronary Heart Disease				
Hypertension				
Plebitis				
Peptic Ulcer				
Gall Bladder Disease				
Colitis				
Anemia				
Rheumatoid Arthritis				
Gout				
Diabetes				
Thyroid Disease				
Hives				
Skin Diseases				
Epilepsy				
Nervous or Mental Disorder				
Drug Allergies				
Fractures				
Hepatitis				
Hay Fever				
Other (please list)				

Are you currently pregnant? Yes ( ) No ( ) Are you planning a pregnancy? Yes ( ) No ( )

Sleep:

Do you usually sleep well? Yes ( ) No ( )

Do you often have difficulty getting to sleep? Yes ( ) No ( )

Do you often wake up during the night and have difficulty getting back to sleep? Yes ( ) No ( )

How often do you take sleeping tablets? Never ( ) Rarely ( ) Once a month ( ) Once a week or more often ( )

How would you describe your usual sleep? ____

Stress

Check the word which best describes the pressure or stress you feel in the following areas of your life.

	None	Low	Medium	High
Job				
Home				
Finances				

Have you ever taken tranquilizers or other sedatives for as long as a week? Yes ( ) No ( )

Have you ever been treated by a physician for nervousness? Yes ( ) No ( )

Please list all your current medications including vitamins, herbs, and over the counter medications:____

What is your preferred pharmacy?

Name:______________________________
Address:____

Phone:______________________________
Fax:____

Do you currently use tobacco? Yes ( ) No ( ) If yes, how much per day?______________________________

Have you ever used tobacco? Yes ( ) No ( ) If yes, when did you quit?____

Do you drink alcohol? Yes ( ) No ( ) If yes, what type? Beer ( ) Wine ( ) Liquor ( ) How many drinks per day?_________________________________

Do you drink caffeinated drinks? Yes ( ) No ( ) If yes how many a day?
____

Do you exercise? Yes ( ) No ( ) If yes, what type?____________________________ How many times per week?______________________________________

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Financial Policy

If we participate with a commercial insurance plan under which you are covered, we will bill the plan for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of deductibles, copayments or coinsurance, and charges for non covered services.

In the event we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance plan.

We are currently Medicare participating providers. We will bill Medicare and most secondary carriers for your visit. You will be responsible for payment of deductibles, copayments or coinsurance, and charges for non covered services. We do not participate with Medicaid.

If you are covered by a Medicare Advantage Program, please notify us so that we can advise you if we participate in that plan. If we do not, you may or may not have out of network benefits. You will responsible for charges at the time of service.

We require a 24 hour advance notice of any cancellation. There will be a $35.00 “no show” fee for appointments not cancelled 24 hours in advance.

Any balances more than 90 days old may be turned to our collection agency. You will then be responsible for any expenses incurred in collecting the overdue amount.

Payments for copays, coinsurance, deductibles are due at the time of the visit.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

________________________ _______ ________________ ____________________

Print patient name **Date** **Date of Birth** **Patient Signature**

______________________________ ____

Print legal guardian name **Legal Guardian Signature**

Lake Mary Psychiatry and Counseling, LLC
PATIENT AUTHORIZATION, CONSENT, AND AGREEMENTS
SIGNATURE FILE FORM

1. **CONSENT TO TREAT**: I request and give consent to Lake Mary Psychiatry and Counseling, LLC to provide and perform such medical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by Lake Mary Psychiatry and Counseling, LLC for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

2. **RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS:** I authorize Lake Mary Psychiatry and Counseling, LLC to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to Lake Mary Psychiatry and Counseling, LLC on my behalf.

3. **MEDICARE CERTIFICATION**: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Lake Mary Psychiatry and Counseling, LLC. or for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

4. **PRESCRIPTION HISTORY**: I give permission to Lake Mary Psychiatry and Counseling, LLC to access my prescription medicine history electronically.

5. **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ACKNOWLEDGMENT** and Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations: I have read this Notice or have had it explained to me. I understand the Notice and have had the chance to ask questions about any matters I don't understand. I request the following restrictions to the use or disclosure of my health information:

______________________________	______________________________	__________
PATIENT'S PRINTED NAME	**PATIENT'S SIGNATURE**	**DATE**
______________________________	______________________________	__________
LEGAL GUARDIAN'S PRINTED NAME	**LEGAL GUARDIAN'S SIGNATURE**	**DATE**

Lake Mary Psychiatry and Counseling, LLC

CONSENT FOR ELECTRONIC MAIL (E-MAIL) USE

Lake Mary Psychiatry and Counseling, LLC offers patients the opportunity to utilize our patient portal to send/receive secure communications or to communicate electronically for non-urgent matters. This form provides the guidelines regarding electronic communications and documents your consent.

IN CASE OF A MEDICAL EMERGENCY, DO NOT USE E-MAIL. CALL 911

Secure messaging or e-mail communication should be between this office and an adult 18 years of age or older, or the parent or guardian of a minor. .

We are creating a patient portal that will be accessible on-line. Your e-mail will allow you to log in to the portal to access certain portions of your medical records, appointment scheduling, communicate with us, etc.

Although Lake Mary Psychiatry and Counseling, LLC has implemented reasonable technical safeguards, we cannot and do not guarantee the privacy, security or confidentiality of an electric message sent or received over the internet. There is a potential that electronic messages sent or received over the internet can be altered, forwarded, and/or read by others. Lake Mary Psychiatry and Counseling, LLC is not responsible for electronic messages that are lost due to technical failure during composition, transmission or storage.

Lake Mary Psychiatry and Counseling, LLC will not forward electronic messages to third independent parties without your prior written consent, except as authorized or required by law.

I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of e-mail as one form of communication with Lake Mary Psychiatry and Counseling, LLC.

____
E-mail Address (please print)

____________________________________ __________________________
Signature of Patient, Parent or Legal Guardian Date

____________________________________ __________________________
Printed Patient Name Relationship (if other than patient)

Lake Mary Psychiatry and Counseling, LLC

Consent to leave messages regarding appointments:

___________ (Initial) I give my consent to leave a message regarding appointment information on voice mail on my home phone or cell phone.

___________ (Initial) I give my consent to leave a message regarding appointment information with the following person or persons who may answer my phone or inquire about appointments:

Name:____ Relationship______________________

Name:____ Relationship______________________

Consent to transmit information electronically

_______ (Initial) I give my consent to transmit appointment information via email and text.

_________ (Initial) I give my consent to transmit medication refill confirmations via text.

Cell Phone:____

Email:____

Patient's Name:____

Patient's Signature:____

Date:________________________________