Steven Rosenzweig, M.D.
123 Chestnut Street; Suite 204; Philadelphia, PA 19106
Tel: 215-627-3782
Email: staff@stevenrosenzweigmd.net
Web: www.stevenrosenzweigmd.net

Intake Packet

1. Registration forms – 2 pages
2. Phone and video visit policy
3. Guidance for ordering natural products
4. Consent for your other providers to send medical records to Dr. Rosenzweig
5. Consent for Dr. Rosenzweig to send medical records to your other providers
6. Medical history intake form

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Registration form page 1

Today's date:		
Patient name		Date of Birth
Address		
Best phone contact number: ☐ Cell ☐ Home ☐ Work	Alternative contact number: ☐ Cell ☐ Home ☐ Work	
Emergency contact – Name:	Relationship:	Phone number:

PRIVACY

WE FOLLOW STANDARD PRIVACY PRACTICES. DID YOU WANT TO RECEIVE A WRITTEN COPY TO READ?

☐ No thanks: I don't need to receive or review a copy of the Notice of Privacy Practices

☐ I have received and reviewed a copy of the Notice of Privacy Practices

WE NEED YOUR PERMISSION TO USE EMAIL

☐ I give permission for my email address to be used for appointment scheduling and reminders.

☐ I give permission for Dr. Rosenzweig and his staff to correspond with me by email about my health information. Every effort is made to protect the confidentiality of all email correspondence. Email is a convenience but is optional.

Email address:

WE NEED YOUR PERMISSION FOR DR. ROSENZWEIG TO DISCLOSE HEALTH INFORMATION TO YOU'RE YOUR HEALTH INSURANCE:

☐ Yes, I give permission to bill my insurance company and send a report back to my referring physician.

WE NEED YOUR PERMISSION FOR DR. ROSENZWEIG TO SEND HIS NOTES TO YOUR OTHER TREATING PHYSICIANS AND THERAPISTS:

☐ Yes, I give permission for Dr. Rosenzweig to send a report to any of my physicians or therapists.

☐ No, Dr. Rosenzweig should only send my information to the following physicians or therapists (please list):

WE NEED YOUR PERMISSION FOR DR. ROSENZWEIG AND HIS STAFF TO DISCUSS YOUR MEDICAL INFORMATION WITH THE FOLLOWING FAMILY, FRIENDS OR HEALTH ADVOCATES (please list):

X_____

Signature of Patient or Authorized Health Representative Date

Patient name: _____

Registration form page 2

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Company:	Company:
ID# Group #	ID# Group #
Name of policy holder	Name of policy holder
Relation to patient	Relation to patient

INSURANCE REFERRAL TO BE SEEN BY DR ROSENZWEIG

☐ My insurance plan does not require a referral or prior authorization to be seen

☐ A copy of my referral has been provided

FINANCIAL RESPONSIBILITY

Name of Person Responsible for Payments:

Relationship to Patient:

Address and Phone Number (if different from above):

Patients are responsible for obtaining referrals if required by their insurance plan. This must be done by the time of the office visit. Otherwise we will need to bill you directly.

Patients are responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service.

Patients may be responsible for additional charges not covered by insurance:

- Charge for missed appointments without 1 complete business day advance notice: $150 for missed initial visit; $75 for missed follow-up visit.
- Charge for returned checks
- Charge to established patients for extensive phone consultations (>10 minutes) or after-hours phone calls requiring diagnosis and treatment (>10 minutes). These phone contacts are not covered by insurance plans and are billed after the first 10 minutes at a prorated, hourly rate
- Charge for the copying and distribution of patient medical records
- Laboratory and other testing – Patients are responsible for verifying their own insurance coverage for any testing ordered by Dr. Rosenzweig.

AUTHORIZATION AND RELEASE

I authorize release of any information concerning my (this patient's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise provided to me directly to Dr. Rosenzweig for his services

X Signature of Patient or Guardian: Date:

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Purchasing Natural Products

The FDA sets high standards for the manufacture of food supplements but does not enforce those standards. Unfortunately, that means that there are many poor quality, and even potentially harmful, products on the market.

However, some companies both comply with FDA standards AND arrange for an independent laboratory to inspect and certify their products. These are the safest and most reliable products to use. Other safe, quality supplements are those manufactured in the European Union and Australia where regulations are enforced by their governments.

Because of these quality issues, I will always recommend a specific product. Many are available through the online dispensary, Wellevate. I always recommend comparison price shopping to purchase the same product elsewhere at a lower price. If you purchase through Wellevate, you'll recieve a 5% practice discount.

Should you wish to order from Wellevate, check that we have registered you. You will receive an email from Wellevate with user information (check you spam folder). Or you can call Wellevate at: 855-935-5382.

Phone and Video Consultation Policy

Insurance companies do not permit us to bill directly for phone and video call consultations. We are glad to provide a paid invoice for these consultations to you.

New patient:
$75 record review +
$200 / hour pro-rated by the minute

Established patient
$200 / hour pro-rated by the minute

Established patient
No charge for brief phone or video call generally under 10 minutes

This form gives permission for your OTHER physicians or health providers to send your health information to Dr. Rosenzweig.

Patient's Name:	**Date of Birth:**

I authorize the following practice(s) to disclose my health information as described below to

Steven Rosenzweig, MD
123 Chestnut Street; Philadelphia, PA 19106
Fax: 888-802-0516; Tel: 215-627-3782

We are NOT requesting:
Psychotherapy reports
Drug and alcohol treatment reports

I am giving permission to include (should this apply to me):
Information about HIV diagnosis and treatment
Information about genetic testing results

NAME OF PHYSICIAN, INDIVIDUAL OR ENTITY	TYPE AND AMOUNT OF INFORMATION
	Recent and future progress notes and test reports

I understand that if I give permission, I have the right to change my mind and revoke it in writing. I also understand that any disclosures already made with my permission cannot be taken back. By signing this Authorization, I understand that any disclosure of information carries the potential for an unauthorized re-disclosure not protected by Federal privacy rules.

SIGNATURE OF PATIENT OR AUTHORIZED HEALTH REPRESENTATIVE	**DATE**

Authorized Health Representative's Name	**Relation to Patient**

This form gives permission to Dr. Rosenzweig to send my information to other healthcare providers.

Patient's Name:	**Date of Birth:**
I authorize Dr. Rosenzweig to share my medical information with my other healthcare providers.	
NAME OF PHYSICIAN, INDIVIDUAL OR ENTITY	TYPE AND AMOUNT OF INFORMATION Recent and future progress notes
I understand that if I give permission, I have the right to change my mind and revoke it in writing. I also understand that any disclosures already made with my permission cannot be taken back. By signing this Authorization, I understand that any disclosure of information carries the potential for an unauthorized re-disclosure not protected by Federal privacy rules.	
SIGNATURE OF PATIENT OR AUTHORIZED HEALTH REPRESENTATIVE	**DATE**
Authorized Health Representative's Name	**Relation to Patient**

Steven Rosenzweig, M.D.

Patient Medical History Intake Form

Visit Date:

Patient Name: **Date of Birth:**

Preferred Pronouns:

How would you prefer to be addressed by Dr. Steve?

Reason for Consultation: Please list the major issue(s) here.

Referred by:

Healthcare Team: Who is the main physician in charge of your treatment (PCP or specialist)?

Other key physicians / healthcare providers who treat you:

PART 1—MEDICAL HISTORY

Past Medical History. Attach list of all medical conditions, diagnoses, or medical problems for which you have been treated or list them here.

Past Surgical History: Please list all major surgeries with dates.

Past Major Physical Injuries: Please list with dates.

Allergies:

Medication(s) Nature of reaction:

Other (food, environmental, etc) Nature of reaction

Medications: Attach complete list of ALL prescription medicines with doses or list here.

Patient Name:_____

Supplements / Herbal Medicines / Homeopathics / Over the Counter Meds: List here or attach list. Include doses.

Advance Care Planning – Living Will and Substitute Decision-Maker:

Have you appointed a substitute decision-maker in the event that you can't make your own medical decisions even temporarily? This is also called having a healthcare proxy or giving someone medical power of attorney.

Name of substitute decision-maker:

Do you have a living will?

Do you need more information about this?

Family Medical History. Medical problems of your family members (including cancer, early heart disease, high blood pressure, diabetes)?

Father:

Mother:

Siblings:

Children:

Other family members with cancer, genetic diseases or other significant diagnoses:

PART 2—SOCIAL HISTORY

Skip any questions you prefer not to answer here

Patient Name:_____

Tobacco: Present use? Past use (number years)?

Alcohol: How many alcoholic beverages to you drink per week?

Past or present alcohol, medication or other chemical dependencies

Diet: Do you adhere to a particular diet?

Social Support:

With whom do you live?

Is home wholesome and safe?

Do you have a good social support or family, friends or neighbors?

Exercise – type, intensity and frequency:

Mind body practices (meditation, yoga, Tai Qi, prayer, etc.):

Other wellness practices – what else do you do to support your health and well-being? Any complementary or alternative therapies?

Biographical: Tell something about your responsibilities, social role, studies, interests, background, daily routine:

Major life stressors and life challenges:

Spiritual or philosophical orientation: Please share something about what gives your life meaning or spiritual practices.

What else would it be helpful for Dr. Rosenzweig to know about you?

Patient Name:_____

PART 3—SYMPTOM REVIEW

Symptom Checklist #1. Please rate symptom intensity in general over the past week. **0** means no symptoms at all and **10** means worst imaginable.

Pain……...0-1-2-3-4-5-6-7-8-9-10	Shortness of breath….0-1-2-3-4-5-6-7-8-9-10
Fatigue/tiredness…0-1-2-3-4-5-6-7-8-9-10	Anxiety/restlessness…0-1-2-3-4-5-6-7-8-9-10
Drowsiness……..0-1-2-3-4-5-6-7-8-9-10	Depressed / sad……0-1-2-3-4-5-6-7-8-9-10
Nausea…….0-1-2-3-4-5-6-7-8-9-10	*Overall diminished* sense of wellbeing…..0-1-2-3-4-5-6-7-8-9-10
Loss of appetite ….0-1-2-3-4-5-6-7-8-9-10	

Symptom Checklist #2. Please indicate **CURRENT or RECENT** symptoms only:

General	☐ Weight loss ☐ Weight gain ☐ Sleep problems ☐ Sweats
Eyes	☐ Dryness ☐ Vision change
ENT	☐ Hearing change ☐ Ringing in ears ☐ Trouble swallowing ☐ Sinus problems
Heart/Circ	☐ Chest pain with exertion ☐ Elevated blood pressures on home monitoring ☐ Irregular heart beat
Breathing	☐ Cough ☐ Wheezing ☐ Pain with breathing
GI	☐ Constipation ☐ Diarrhea ☐ Excessive gas ☐ Blood or abnormal color of bowel movement
Urological	☐ Pain with urination ☐ Abnormal frequency of urination
Muscle/Joint	☐ Muscle pain ☐ Muscle cramps ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling
Neurologic	☐Faintness or dizziness ☐ Headaches (not just mild & occasional) ☐ Balance problems ☐ Memory problems ☐ Concentration problems
Endocrine	☐ Excessive thirst ☐ Hot flashes ☐ Hair thinning
Blood	☐ Abnormal bleeding ☐ Abnormal bruising
Skin	☐ Rash ☐ Sores ☐ Abnormal bumps
Immune:	☐ Hives ☐ Swollen glands ☐ HIV positive

Thank you!