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

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 POLICY

NOTICE OF PRIVACY PRACTICES

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

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

EMAIL

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

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

Email address:

PERMISSION FOR DR. ROSENZWEIG TO DISCLOSE HEALTH INFORMATION

1. Your referring physician. If you required a physician referral for insurance purposes, Dr. Rosenzweig must send a report back to the referring physician. You may refuse this, but we would not be able to bill insurance for your visit.

2. Your other current treating physicians / therapists. It is often important for Dr. Rosenzweig to send a report to another physician who is actively treating you.

☐ Yes, Dr. Rosenzweig may send a report to any of my current physicians or therapists.

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

3. I give consent to Dr. Rosenzweig and his staff to discuss my medical information with the following family members, friends, or health advocates:

X_____

Signature of Patient or Authorized Health Representative Date

Patient name: _____

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:

Patient's Authorization For Dr. Rosenzweig to Disclose Protected Health Information

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

I authorize the practice of Steven Rosenzweig, MD to disclose my health information as described below.

Check as appropriate:

☐ INCLUDE / ☐ DO **NOT** INCLUDE: any and all psychological and psychiatric information (separate authorization is required for psychotherapy notes)

☐ INCLUDE / ☐ DO **NOT** INCLUDE: any and all drug and alcohol treatment information

☐ INCLUDE / ☐ DO **NOT** INCLUDE: any and all HIV/AIDS related treatment information

☐ INCLUDE / ☐ DO **NOT** INCLUDE: any and all genetic information

NAME OF PHYSICIAN, INDIVIDUAL OR ENTITY	TYPE AND AMOUNT OF INFORMATION (e.g. Progress notes, test results, outside 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**