ColumbiaDoctors



# New Patient Intake Form

## Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Gender: _____

Home Address: _____ City, ST: _____ Zip: _____

Home Phone: _____ Other Phone: _____ Preferred: Home Other

Patient Email Address: _____ Marital Status: _____

Guarantor/Parent: _____ Date of Birth: ____/____/____

Address: _____ City, ST: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

Guarantor/Parent Email Address:

Emergency Contact (if other than guarantor): _____

Emergency Phone: _____ Relationship to Patient: _____

## Insurance Information

Insurance Company Name: _____

Insurance Address: _____ City, ST: _____ ZIP: _____

Certificate/Plan/ID #: _____ Group (Grp): _____

Subscriber (if other than patient or guarantor): _____

Subscriber Address: _____ City, ST: _____ ZIP: _____

Subscriber Date of Birth: ____/____/____ Relationship to Patient: _____

## Patient Employment Information

Employer: _____ Occupation: _____

Employer Address: _____ City, ST: _____ Zip: _____

Patient Work Phone: _____

## Text Messaging Agreement

□ I consent to receive messages from ColumbiaDoctors for my healthcare services at the phone number(s) above, and my wireless (fill in) _____. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

□ Opt out

Last Name: _____ First Name: _____ DOB: / /

Please provide information regarding your health care providers in the spaces below:

| | Name | Phone | Location | Date of last visit |
|---|---|---|---|---|
| Primary Care | | | | / / |
| Psychiatrist | | | | / / |
| Psychotherapist | | | | / / |
| Dentist | | | | / / |

Preferred Pharmacy: _____ Pharmacy Phone: _____

Preferred Pharmacy Address: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- □ Decline Response
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Race:

- □ Decline Response
- □ American-Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Pacific Islander
- □ White
- □ Other

Preferred Language: _____ □ Decline Response

Patient Signature: _____ Date: _____

# TRUSTEES OF COLUMBIA UNIVERSITY - DEPARTMENT OF PSYCHIATRY
# PATIENT FINANCIAL AGREEMENT

I_____ (Patient Name) acknowledge the payment and insurance information set form below and agree to pay for services rendered to me and/or facilitate the payment for services rendered to me by the programs and physicians and other health care providers affiliated with Trustees of Columbia University, Department of Psychiatry, and Columbia physicians from other medical specialties asked to consult on my care by the psychiatric treatment team.

1. Payment of Fees: I agree to pay for charges for services as described in this agreement. I know that I may request and will receive a written fee schedule. Columbia may change its fees in the future. **Insurance coverage may not pay for all my services.** In some instances, payment will be solely my responsibility. I understand that:
   - Payment for regular outpatient service is due at the time of treatment. NOTE: I will be charged for outpatient appointments I do not keep, unless I cancel the appointment at least 24 hours in advance. I understand that I cannot submit bills for cancellations to my insurance company or managed care plan.
   - Payment for a Telephone Session is an out of pocket expense. I understand that Telephone Session is a non-covered service by my insurance company or managed care plan (Calls 16min or longer are billed as a telephone session.)
   - Payment for day treatment must have a credit card on file otherwise; a month in advance check is required based on my treatment plan.
   - Bills for inpatient treatment are sent after discharge. However, if I do not have insurance coverage for inpatient treatment I will have to pay in advance for the expected length of my stay in the hospital. Columbia will refund overpayments within 6-8 weeks.
   - Columbia offers Ketamine infusions. This service is not covered by insurance. The price is **$_____** an infusion. If I choose to receive this service, payment will be my responsibility.
   - Substance Abuse services may require laboratory testing. These tests can be billed to your insurance plan with variable coverage rates. Payment will be my responsibility.
2. Insurance and Managed Care Plans: Columbia participates in a number of insurance and managed care plans. If Columbia participates in my plan, I agree to pay all applicable charges, deductibles, co-payments, co-insurances. If Columbia does not participate in my insurance plan, Columbia may, at its discretion, accept assignment from my plan. If Columbia accepts such assignment, I agree to pay any charges, deductibles and co-payments required by my plan. If my insurance benefits run out, Columbia will inform me of the ending date, and I will then be responsible for all charges dating from the end of insurance coverage. If my insurance plan denies the visit despite Columbia following necessary procedures, I understand I will be responsible to pay in full for the service.
3. Assignment of Insurance Fees; Release of confidentiality for authorization of benefits and for clinical care: I agree to allow my insurance plan or managed care plan to pay Columbia directly, instead of paying me. In the event that my plan pays me directly, I will promptly turn the payment over to Columbia unless I have already paid the charges myself.

   I authorize Columbia to provide my insurance plan or managed care plan any information reasonably required to obtain insurance benefits and authorization for services. I authorize Columbia to obtain at any time during my treatment here, any and all relevant clinical information from clinicians and facilities that have treated me and to furnish relevant clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this. If the insurance or managed care plan deny the service
4. I have signed a HIPAA [patient privacy laws and regulations] acknowledgment with the Department.
5. I understand Columbia may release me as a patient if I do not adhere to this agreement. If this happens, Columbia will assist me in making alternative arrangements for my treatment, if necessary.
6. Name of responsible party: _____Rel. to patient: _____

   Signature: _____Telephone: Work_____Home_____

   Address of responsible party: _____
7. Credit Card Authorization for co-payments and fees by faculty physicians and providers of Columbia University

   Circle one: *Visa MasterCard Amex Discover* Account No: _____Exp._____

   CVV: _____

   Signature: _____Date:_____

**TELEHEALTH TERMS OF USE** IMPORTANT INFORMATION ABOUT YOUR USE OF THE SERVICE

Telehealth Services (“Service”) provides evaluation, diagnosis, consultation, and treatment using an interactive audio and video telecommunications system that permits real-time communication between you and your provider.

DO NOT USE THIS SITE FOR EMERGENCY MEDICAL NEEDS. If you experience a medical emergency, call 911 immediately.

You acknowledge that your ability to access and use the Service is conditioned upon the truthfulness of this certification and that the Providers you access are relying upon this certification in order to interact with you. In the event that your certification is inaccurate, you agree to indemnify the healthcare providers you interact with from any resulting damages, costs or claims.

I UNDERSTAND:

- Telehealth visits are clinical visits, rules and confidentiality apply.
- I have the right to withhold or withdraw my consent for the use of Telehealth at any time, without affecting my right to future care or treatment.
- If I am a parent/legal guardian engaging Telehealth services on behalf of a minor child or person who lacks capacity to provide consent, I will consent and be present for the visit and I further understand that special circumstances may apply.
- I will be informed of the clinical staff, involved in my care, present during my Telehealth service.
- The laws that protect privacy and the confidentiality of medical information also apply to Telehealth, and that no information obtained in the use of Telehealth which identifies me will be disclosed to researches or other entities without my consent.
- I have the right to request copies of my health information, including records of my Telehealth visit, and receive copies of this information, in accordance with applicable federal and state law, for a reasonable fee.
- My insurance carrier may have access to my medical records for payment and/or quality assurance.
- My insurance may be billed for the Telehealth service and that I will be responsible for the copay, co-insurance, deductible, and other patient responsibility.
- My health information may be shared by my Providers with other medical providers, who may be located in other areas including out of state, by electronic or other means, in order to improve my medical care.
- My Provider will determine whether or not the condition being diagnosed and/or treated is appropriate for a telehealth encounter via the Service.
- If my Provider determines that the Telehealth services do not adequately address my medical needs, my Provider may require an in-person medical evaluation. In the event the Telehealth session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary.

DISCLAIMERS

Access to the service and the information contained therein is provided "as is" and "as available" without any warranty of any kind, express or implied.

Without limiting the foregoing, neither my Provider nor any organization with whom my Provider is affiliated for the provision of Telehealth warrants that access to the service will be uninterrupted or error-free, or that defects, if any, will be corrected; nor does it make any representations about the accuracy, reliability, currency, quality, completeness, usefulness, performance,

security, legality or suitability of the service or any of the information contained therein. You expressly agree that your use of the service and your reliance upon any of its contents is at your sole risk.

AGE REQUIREMENTS

I hereby certify that I am at least 18 years of age and/or am legally qualified and able under the laws of my state to make medical decisions on my own behalf, or on behalf of my minor child or the adult person on whose behalf I have requested this visit, if applicable. I acknowledge that my ability to access and use Telehealth services, and information is conditional upon the truthfulness of my certification of age.

GEOGRAPHIC RESTRICTIONS

I hereby certify that I am located in an eligible service area and agree to only interact with a Provider through Telehealth services, while I am present in that service area. I acknowledge that my ability to access and use these services is conditional upon the truthfulness of the certifications I make at the time of accessing a Provider, and that the Providers I access are relying upon this certification in order to interact with me.

PATIENT CONSENT TO THE USE OF TELEHEALTH

By clicking the "I Accept" button I acknowledge the scope of care will be at the sole discretion of the healthcare provider who is treating me, with no guarantee of diagnosis, treatment, or prescription. I have read and understand the information provided above, and understand the risks of telehealth, and by accepting these Terms of Use I hereby give my consent for the use of telehealth for my medical care.

PRIVACY POLICY

For more information about how your health information is handled, please see the notice of privacy practices at https://www.nyp.org/pdf/privacy_notice_english.pdf.