NYC Neuropsychiatry

303 Fifth Ave, Suite 1707
New York, NY 10016
nycneuropsychiatry@gmail.com
347-377-0959
fax: 210-892-3629

3600 Fieldston Road, Suite 2K
Bronx, NY 10463
paulcampionmd@gmail.com
201-292-7987
fax: 210-892-3629

NEW CLIENT REGISTRATION

Date: _____/_____/_____

Name: _____

Date of Birth: ____/_____/____ Age: _____

Social Security number (optional): _____-_____-_____

Mailing Address: _____

Email address: _____

Preferred phone: _____ [ ] cell [ ] home [ ] work

Permission to leave detailed messages on this phone? [ ] yes [ ] no

Other phone: _____ [ ] cell [ ] home [ ] work

Permission to leave detailed messages on this phone? [ ] yes [ ] no

Referred by: _____ Phone: _____

Current Therapist: _____ Phone: _____

Emergency contact: _____ Phone: _____

Allergies to Medication: _____

Pharmacy: _____ Address: _____

Phone: _____

Insurance: _____ ID#: _____ Group#: _____

Insurance Phone Number (Provider Line): _____

NYC Neuropsychiatry

303 Fifth Ave, Suite 1707
New York, NY 10016
nycneuropsychiatry@gmail.com
347-377-0959
fax: 210-892-3629

3600 Fieldston Road, Suite 2K
Bronx, NY 10463
paulcampionmd@gmail.com
201-292-7987
fax: 210-892-3629

BILLING AND CANCELLATION POLICY

Payment and/or copayment is due at the time of each session unless agreed upon otherwise. Any session cancelled with less than 48 hours notice, weather permitting, will be billed the full fee. Payment may be made by cash, check (written to 'NYC Neuropsychiatry'), credit card, Zelle, or Venmo (sent to @nyc-neuropsychiatry). A 3% surcharge will be added to card transactions.

Acknowledged and accepted by:

Name: _____

Signature: _____

Date: _____

CREDIT CARD AUTHORIZATION

I, _____, authorize NYC Neuropsychiatry to charge my credit card for psychiatric services including missed appointments and understand that NYC Neuropsychiatry is required to have a copy of my credit card on file for this purpose.

_____ Signature

Circle one: MasterCard / VISA /AMEX

_____ Credit Card Number

_____ Security Code

_____ Expiration Date

_____ Billing Zip Code

_____*Date*

NYC Neuropsychiatry

303 Fifth Ave, Suite 1707
New York, NY 10016
nycneuropsychiatry@gmail.com
347-377-0959
fax: 210-892-3629

3600 Fieldston Road, Suite 2K
Bronx, NY 10463
paulcampionmd@gmail.com
201-292-7987
fax: 210-892-3629

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES AND POLICIES

NYC Neuropsychiatry

In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

I have received a copy of the Notice of Privacy Practices and Policies from:

NYC Neuropsychiatry

Patient Signature: _____

Date: _____

NYC Neuropsychiatry

303 Fifth Ave, Suite 1707
New York, NY 10016
nycneuropsychiatry@gmail.com
347-377-0959
fax: 210-892-3629

3600 Fieldston Road, Suite 2K
Bronx, NY 10463
paulcampionmd@gmail.com
201-292-7987
fax: 210-892-3629

CONSENT TO ELECTRONIC COMMUNICATION USE

By signing below, I consent to the use of electronic communication between myself, _____, and NYC Neuropsychiatry. I recognize that there are risks to its use, and despite NYC Neuropsychiatry's best efforts, one cannot absolutely guarantee confidentiality. I understand and accept those risks and the policies for email, text messaging, voicemail, Doxy.me, Skype, FaceTime use outlined in the form. I further agree to follow these policies and agree that if I should I fail to do so, NYC Neuropsychiatry may cease to allow me to use electronic methods to communicate with my doctor. I also understand that I may withdraw my consent to communicate via email, text message or voicemail at any time by notifying NYC Neuropsychiatry in writing.

_____

Printed name of Patient/Guardian

_____

Signature of Patient/Guardian

_____

Date

NYC Neuropsychiatry

303 Fifth Ave, Suite 1707
New York, NY 10016
nycneuropsychiatry@gmail.com
347-377-0959
fax: 210-892-3629

3600 Fieldston Road, Suite 2K
Bronx, NY 10463
paulcampionmd@gmail.com
201-292-7987
fax: 210-892-3629

ELECTRONIC COMMUNICATION CONSENT: GUIDE TO EMAIL, TEXT MESSAGE AND VOICEMAIL USE

As a supplement to your in-office appointments, NYC Neuropsychiatry is inviting you to use electronic methods to communicate with the practice. Set forth below are policies outlining when and how email, text messaging and voicemail should be utilized to maintain your privacy and to enhance communication as well as a place for you to acknowledge your consent to its use. Your decision to utilize these methods is strictly voluntary and your consent may be rescinded at any time.

Telephone communication between sessions is sometimes necessary and is a usual part of treatment. For example, a medication needs to be renewed before the next scheduled session, or to cancel or reschedule a session, or even an unusual personal emergency. In certain circumstances, sessions must be conducted over the phone or via video conferencing. Skype and FaceTime are non-secure video software platforms and patients who agree to communicate using these platforms must consent to doing so. Doxy.me is a HIPAA compliant video software platform used by NYC Neuropsychiatry.

Phone conversations and email exchanges >10 minutes in length will be billed at NYC Neuropsychiatry's hourly rate, including calls with family members, significant others, teachers, and clinicians with whom you have asked NYC Neuropsychiatry to communicate. Unfortunately, many insurance companies do not reimburse patients for phone sessions or email exchanges.

NYC Neuropsychiatry does not use text messages.

NYC Neuropsychiatry's voicemail is transcribed and communicated to your doctor via email. While email is generally reliable and secure, this email is not encrypted. NYC Neuropsychiatry's voicemail is transcribed via Google Voice and sent to the office G Suite account. If you have any concerns about what you might leave in a voicemail or email, wait until we are speaking on the phone or in person. Email will be checked at least once daily. You may expect any required response to emails within 2 to 3 business days. Faxes are also sent and received electronically via Doximity Fax, a HIPAA secure online fax service. If you would prefer not to fax anything, you may choose to mail it instead.

You may use the Luminello secure portal to send HIPAA-complaint messages to your doctor. These messages may become a part of your permanent medical record.

The best way to communicate with NYC Neuropsychiatry is to call the office phone number and leave a voicemail. We respond to voicemails within 1 to 2 business days. The office phone number accepts calls on weekends as well and we do receive voicemails on weekends. If your doctor is out of town, your doctor will leave emergency coverage contact information.

If you need more rapid attention for your own or someone else's safety, do not delay while waiting for your doctor to return your telephone call. Please call 9-1-1 or report to the nearest hospital emergency room.

Invoices are sent electronically via email as an email attachment. Invoices will be sent to your email, which is not secure. Your bill will list your diagnosis code, E&M procedure codes for your sessions, your date of birth and contact information. You have the option to receive your invoices in paper format instead of via email. Payments via credit card are made using Luminello and Bluefin, which are both secure encrypted credit card processing applications.

The following Frequently Asked Questions below pertains to use of email, but also applies to electronic communication of any kind.

When may I use email to communicate with my doctor?
Email may be used for:
- Appointment requests, cancellations, and rescheduling
- Non-clinical matters
- Other matters not requiring an immediate response

When should I NOT use email to communicate with my doctor?
Email should never be used:
- In an emergency
- If you are experiencing any desire to harm yourself or others
- If you are experiencing a severe medication reaction
- If you need an immediate response
- For clinical matters of any kind

What are the risks of using email?
Risks of communicating via email include, but are not limited to:
- Email may be seen by unintended viewers if addressed incorrectly
- Email may be intercepted by hackers and redistributed
- Someone posing as you could access your information
- Email can be used to spread computer viruses
- There is a risk that emails may not be received by either party in a timely matter as it may be caught by junk/spam filters
- Emails are discoverable in litigation of any kind and may be used as evidence in court
- Statements made via email may be misunderstood thus creating miscommunication and/or negatively affecting treatment
- There may be an unanticipated time delay between messages being sent and received

What happens to my messages?
- Emails will not be part of your medical record and will remain in the G Suite inbox unless they are deleted, although they still remain on the Google server.

What are my obligations?
- I must let my doctor know immediately if my email address changes or if I would prefer not to continue communicating via email
- If I do not receive a response from my doctor in the time frame indicated, I will contact my doctor by telephone if a response is needed
- I will use email communication only for the purposes stated above
- I understand that email may only be used to supplement my appointments with NYC Neuropsychiatry and not as a substitute for them

What steps has NYC Neuropsychiatry taken to protect the privacy of my email communications?
Your doctor

- Does not allow family members or friends to access to the office computer
- Will not transmit highly sensitive information via email
- Computer and phone are password protected
- Will not leave email communication open or visible when away from the computer

What steps can I take to protect my privacy?

- Do not use your work computer to communicate with NYC Neuropsychiatry as your employer has a right to inspect emails sent through the company's system
- Do not use a shared email account to transmit messages
- Log out of your email account if you will be away from your computer
- Carefully check the address before hitting "send" to ensure that you are sending your message to the intended receiver
- Avoid writing or reading emails on a mobile device in a public place or using a public WiFi hotspot
- Make certain that your email is signed with your first and last name and include your date of birth to avoid possible mix up with patients with same or similar names.

Signature _____

Printed name: _____

Date: _____

NYC Neuropsychiatry

303 Fifth Ave, Suite 1707
New York, NY 10016
nycneuropsychiatry@gmail.com
347-377-0959
fax: 210-892-3629

3600 Fieldston Road, Suite 2K
Bronx, NY 10463
paulcampionmd@gmail.com
201-292-7987
fax: 210-892-3629

Health Insurance Information

Unless you have made specific arrangements with your doctor beforehand, NYC Neuropsychiatry is an out-of-network provider, meaning that the practice does not accept payments from insurance companies. If you are interested in seeking reimbursement from your insurance company, contact it directly to obtain information about your "out-of-network behavioral health coverage". You will want to confirm: 1) if you have a deductible; 2) what percentage of fees are covered; 3) in what time period claims must be filed; and 4) what your company considers "reasonable and customary" for zip code for the practice, which means the rate at which they will reimburse you for treatment. Some companies may request a procedure code in addition to a zip code to determine their reimbursement rate.

At the end of the visit, your doctor will provide invoices for rendered services. These invoices will include diagnosis codes and description of services (CPT codes) rendered. You can attach these invoices to your insurance claim forms to submit to your insurance company.

Signature _____

Printed name: _____

Date: _____

NYC Neuropsychiatry

303 Fifth Ave, Suite 1707
New York, NY 10016
nycneuropsychiatry@gmail.com
347-377-0959
fax: 210-892-3629

3600 Fieldston Road, Suite 2K
Bronx, NY 10463
paulcampionmd@gmail.com
201-292-7987
fax: 210-892-3629

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices, but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the State of New York. This includes issues relating to your treatment, payment, and our healthcare operations. Your personal health information will never otherwise be given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released. The HIPAA officer for this practice is Deepti Anbarasan, MD.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality healthcare, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone numbers, social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machine messages, and postcards.

PATIENT RIGHTS

You have the right to request copies of your healthcare information, to request copies in a variety of formats, and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

NYC Neuropsychiatry

Please sign this form as acknowledgement of receipt.

Signature _____

Printed name: _____

Date: _____

NYC Neuropsychiatry

303 Fifth Ave, Suite 1707
New York, NY 10016
nycneuropsychiatry@gmail.com
347-377-0959
fax: 210-892-3629

3600 Fieldston Road, Suite 2K
Bronx, NY 10463
paulcampionmd@gmail.com
201-292-7987
fax: 210-892-3629

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize NYC Neuropsychiatry to:

□ Release information to:

□ Obtain information from:

□ Exchange information with:

Name: _____

Contact information: _____

The information requested or authorized for release or exchange pertains to:

□ All information regarding assessment, diagnosis and treatment

□ Mental Health

□ HIV/AIDS

□ Drug or Alcohol Abuse

This authorization is valid until date _____.

I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my treatment. I understand that there may be a fee associated with the copying of my records.

Signature: _____

Printed Name: _____ **Date: _____**