PATIENT INFORMATION FORM **MARSHALL TEITELBAUM, M.D.**

(Please Print) TODAY'S DATE:____________________ DATE OF BIRTH:______________

PATIENT NAME:____
First MI Last

STREET ADDRESS:____

CITY:______________________ STATE:_____ ZIP:______________________

HOME # __________ WORK # ________ CELL # __________ GENDER PREFERENCE ___

SOCIAL SECURITY NUMBER:____________________ EMAIL ADDRESS: ____________

EMPLOYER:______________________ SCHOOL:______________________

STUDENT: PART-TIME FULL-TIME PART-TIME EMPLOYED FULL-TIME EMPLOYED

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

NEXT OF KIN:________________ REFERRING PHYSICIAN:______________________

PHARMACY : ______________________ PHARMACY PHONE#:____________________

PHARMACY ADDRESS:____

____

GUARANTOR INFORMATION-IF PATIENT UNDER 18 YEARS OLD

NAME:____ GENDER PREFERENCE _____
First MI Last

DATE OF BIRTH:____________________ RELATIONSHIP TO PATIENT:______________

ADDRESS:________________________ CITY:____________ STATE:_____ ZIP:________

HOME# __________________ WORK #____________________ CELL #______________

SOCIAL SECURITY NUMBER:____________________ EMPLOYER:________________

NAMES OF PARENTS WITH RIGHTS TO MEDICAL DECISIONS: ______________________

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TREATMENT/PATIENT AUTHORIZATION: THE UNDERSIGNED AUTHORIZES MARSHALL TEITELBAUM/PROFESSIONAL STAFF TO ADMINISTER PSYCHIATRIC TREATMENT. I **UNDERSTAND** THAT I MAY BE **CHARGED** FOR AN OFFICE VISIT IF A SCHEDULED APPOINTMENT IS **NOT CANCELED** AT LEAST **24 BUSINESS HOURS PRIOR** TO THE APPOINTMENT TIME **OR** MY **ARRIVAL** TIME FOR A SCHEDULED APPOINTMENT IS **DEEMED TO BE TOO LATE** TO BE SEEN.

AFTER THE INITIAL EVAL AND FIRST FOLLOW-UP APPOINTMENTS HAVE TAKEN PLACE, DR. TEITELBAUM REQUIRES AT LEAST QUARTERLY VISITS TO MAINTAIN A PROPER STANDARD OF CARE. A POSSIBLE DISCHARGE FROM THE PRACTICE COULD RESULT IF THREE (3) OFFICE VISITS ARE MISSED DUE TO NONCOMPLIANCE OF TREATMENT AND ELEVATED MALPRACTICE RISK.

LEGAL ISSUES: I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT ON ANY LEGAL ISSUES SUCH AS DEPOSITIONS, CHART REVIEW, PAPERWORK OR COURT APPEARANCES AT A BILLING RATE OF $750 PER HOUR.

PAYMENT OF SERVICES: I AM AWARE THAT **DR. TEITELBAUM DOES NOT ACCEPT OR FILE INSURANCE PLANS.** PAYMENT IS REQUIRED IN FULL AT THE TIME OF EACH VISIT VIA CASH, CREDIT CARD OR CHECK. IF A CHECK IS RETURNED, THE FEE IS $40.00

I UNDERSTAND IF I HAVE AN UNPAID BALANCE TO MARSHALL TEITELBAUM, M.D. AND DO NOT MAKE SATISFACTORY PAYMENT ARRANGEMENTS, MY ACCOUNT MAY BE PLACED WITH EXTERNAL COLLECTION AGENCY. I WILL BE RESPONSIBLE FOR REIMBURSEMENT OF THE FEE OF ANY COLLECTION AGENCY, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 35% OF THE DEBT, AND ALL COSTS AND EXPENSES, INCLUDING REASONABLE COLLECTION AND ATTORNEY'S FEES INCURRED DURING COLLECTION EFFORTS.

IN ORDER FOR MARSHALL TEITELBAUM, M.D. OR THEIR DESIGNATED EXTERNAL COLLECTION AGENCY TO SERVICE MY ACCOUNT AND WHERE NOT PROHIBITED BY APPLICABLE LAW, I AGREE THAT MARSHALL TEITELBAUM, M.D. AND THE DESIGNATED EXTERNAL COLLECTION AGENCY ARE AUTHORIZED TO (I) CONTACT ME BY TELEPHONE AT THE TELEPHONE NUMBER(S) I AM PROVIDING, INCLUDING WIRELESS TELEPHONE NUMBERS, WHICH COULD RESULT IN CHARGES TO ME, (II) CONTACT ME BY SENDING TEXT MESSAGES (MESSAGE AND DATA RATES MAY APPLY) OR EMAILS, USING ANY EMAIL ADDRESS I PROVIDE AND (III) METHODS OF CONTACT MAY INCLUDE USING PRE-RECORDED/ARTIFICIAL VOICE MESSAGE AND/OR USE OF AN AUTOMATIC DIALING DEVICE, AS APPLICABLE.

SIGNATURE:______________________________ DATE:________________________

AUTHORIZATION TO LEAVE MESSAGES
Marshall Teitelbaum, M.D.

Patient Name: ______________________ Date of Birth: _____________

Dear Patient:

We would like to make your life easier. For your convenience, we will text/phone you to remind you of your appointments and respond to any messages you leave for the office. There may also be instances when the doctor needs to change your appointment. To protect your confidentiality, your permission is needed to leave a message with anyone other than yourself.

Please circle your choices:

Spouse Relative Friend Answering machine

Person's name: _________________________

__________________________ ____________________
Signature - Patient, Parent or Guardian Date

I DO NOT GIVE PERMISSION TO LEAVE MESSAGES
(circle if this is your choice)

__________________________ ____________________
Signature - Patient, Parent or Guardian Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize and request

Marshall Teitelbaum, M.D.
641 University Blvd., Suite 206
Jupiter, FL 33458
561-630-8530
Fax: 561-630-8531

To release confidential professional information, including person, psychological, psychiatric, substance abuse, AIDS-related information, and medical records and opinions resulting from my contacts with them to:

Name: ______________________________

Address: ______________________________

____

Phone: ____________ **Fax:** ____________

This request specifically includes the following:

( ) Discharge Summary
( ) Progress Notes
( ) Laboratory Results
( ) Psychological testing
( ) Psychosocial History
( ) Other

Dates to be covered by reports: From: ____________ To: ____________ I also authorize ____________________ (or one of his/her associates) to communicate with ____________________ regarding all aspects for my treatment, diagnosis and prognosis.

I UNDERSTAND THAT I HAVE NO OBLIGATION TO DISCLOSE THE REQUESTED INFORMATION AND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY INFORMING ANY OF THE ABOVE NOTED INDIVIDUALS. IN CONSIDERATION OF THIS CONSENT, I HEREBY RELEASE THE ABOVE PARTIES FROM ANY AND ALL LIABILITY ARISING THEREFROM.

____________________ ____________________
Please print patient's name here Date of Birth

____________________ ____________________
Signature - Patient, Parent or Guardian Date

____________________ ____________________
Witness Date

Marshall Teitelbaum, M.D.
641 University Blvd., #206
Jupiter, FL 33458
561-630-8530
Fax: 561-630-8531

Tax ID - 65-1120940
NPI # - 1336241207

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Dr. Teitelbaum's fees are as follows:

Initial evaluation	$500
One hour appointment	$450
30 minute follow up (most visits)	$275

You will be charged at the time of each visit.

Please note we have a one business day cancellation policy. If you do not cancel with at least one business day's notice, you will be responsible for the full appointment fee.

If we are obligated to send your account to collections due to non-payment, you will be charged an additional fee that equals 35% of your balance, as well as all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

Dr. Teitelbaum's legal fees are charged at $750/hour. This includes time spent on record review in addition to time spent in depositions, court, and time required out of the office.

We reserve the right to charge up to $1.00/page for medical records and up to $50 for a letter written by Dr. Teitelbaum. Form completion *may* also incur an expense based on the required time needed proportionately to follow-up appointment rates.

These fees do no not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

_______________________________ _______________
Print patient Name Date of birth

_______________________________ _______________
Signature - patient, parent or guardian Date

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises