Marshall Teitelbaum, M.D. (F99252)
641 University Blvd Suite 206
Jupiter, FL 33458-2970
Phone: (561) 630-8530
Fax: (561) 630-8531

PLEASE COMPLETE ENTIRE ATTACHED PACKET

Dear Patients / Families,

First, **welcome to my practice**. The following is to give a brief overview of the office.

My goal is to serve patients with consideration and respect. To allow my office staff to meet your needs, the answering service will take phone calls until:
9:30am, from noon – 1pm after 3:30pm each business day.

During the time the answering service is covering the telephones, only calls of an emergent nature will be received. These may include severe medication reactions, suicidal or homicidal feelings, psychotic symptoms, or a sudden extreme change in the patient's overall function. If it is felt that the situation requires emergent care prior to speaking to me, please go to the emergency room immediately to ensure safety of self and others. In addition, the answering service will take a message regarding an appointment confirmation or cancellation.

Medication refill requests are not considered to be emergencies and must occur during regular business hours. For refills requiring hard-copy prescriptions, please call or fax 5-7 days in advance to ensure timely reception. Let us know if you'd prefer to pick up the prescription directly.

Cancellation policy: As a courtesy my office makes every effort to call and remind you of your appointment two business days in advance. If you are unable to keep your appointment, one full (24 hours) business day's notice is required to avoid a cancellation charge. You may call or fax to accommodate any needs, including those about scheduling or clinical care.

I appreciate you giving me the opportunity to assist in the care of your family and /or you.

Sincerely,

Marshall Teitelbaum, M.D.

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 PHONE:_____ WORK PHONE:_____ 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:_____

GUARANTOR INFORMATION

NAME:_____ GENDER PREFERENCE:_____
First MI Last

DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____

SOCIAL SECURITY NUMBER:_____ EMPLOYER:_____

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 CANCELLED** 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 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 $600 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 AN 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 (1) CONTACT ME BY TELEPHONE AT THE TELEPHONE NUMBER(S) I AM PROVIDING, INCLUDING WIRELESS TELEPHONE NUMBERS, WHICH COULD RESULT IN CHARGES TO ME, (2) CONTACT ME BY SENDING TEXT MESSAGES (MESSAGE AND DATA RATES MAY APPLY) OR EMAILS, USING ANY EMAIL ADDRESS I PROVIDE AND (3) 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 $650/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

Marshall Teitelbaum, M.D.

Medical and Developmental History

1. Medical History:

Current medications/dosages:

Drug allergies, including type of reaction seen:

History of previously performed surgery, including dates:

History of fractures, stitches, or other significant accidents:

History of seizures, head injuries or loss of consciousness:

History of heart problems ***for patient or close relatives***:

Medical tests performed, including bloodwork, over the last year:

For women, is there any possibility you may be pregnant or nursing at this time or expecting to be in the near future:

2. Developmental History (for children and teens):

Gestational age in weeks (ie premature, full- or post-term):

Birthweight:

Mother's medical problems during the pregnancy (ie medications used, substance use, illnesses , injuries):

Delivery method: vaginal or C-section

Length of labor in hours:

Early medical problems seen (ie jaundice, colic, hospitalizations, etc.):

Any developmental delays (ie onset of walking, talking, or potty training):

BDI **********Date:_____

Name:_____Martial Status:_____Age:____Sex____

Occupation:_____Education:_____

This questionnaire consist of 21 groups of statements. After reading each group of statements carefully circle the number (O,1,2,or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the day.
   2 I feel guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anyone else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever was.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

Subtotal_____Page # 1 Continued on next page

14. 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes_____ No_____

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

_____ Subtotal Page 2
_____ Subtotal Page1

_____ Total Score