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,

M Teitelbaum

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 # _____ 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: _____

_____

_____

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

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):

CONNOR'S RATING SCALE
(CHILDREN)

Child Name:_____ **Date**_____

Completed By:_____

OBSERVATION	NOT AT ALL	JUST A LITTLE	PRETTY MUCH	VERY MUCH
Inattention				
1. Often Fails To finish things he or she starts				
2.Often doesn't seem to listen				
3.Easily Distracted				
4.Has Difficulty concentrating on school work Or other tasks requiring substaned attention				
5. Has difficulty sticking to a play activity				
Impulsivity				
1.Often acts before thinking				
2.Shifts excessively from one activity to another				
3.Has difficulty organizing work(this is not due to cognitive impairment)				
4.Needs a lot if supervision				
5.Frequently calls out in class				
6.Has difficulty awaiting turn in games or Group activity				
Hyperactivity				
1.Excessively runs about or climbs on things				
2.Has difficulty sitting still or fidgets excessively				
3.Has difficulty staying seated				
4.Moves about excessively during sleep or rest time				
5.Is always"on the go" or acts as if "driven by a Motor"				
Peer Interaction				
1.Fights, hits,punches, etc				
2.Is disliked by other children				
3.Frequently interrupts other children's activities				
4.Bossy,always telling other children what to do				
5.Teases or calls other children names				
6.Refuses to participate in group activities				
7.Loses temper often and easily				