NEW PATIENT INFORMATION SHEET

Name: _____ Birth Date: _____Sex: ____M____F
Address: _____ZIP: _____
City/State: _____SS# __ __ __- __ __- __ __ __ __
Home Phone#: (____) _____Work Phone#: (____) _____Cell Phone#: (____) _____
Appointment Reminder Call Contact # *(please circle one): Home Work Cell Other: (____)* _____

IF PATIENT IS A MINOR:
Mother's Name: _____ Birth Date: _____
SS#: __ __ __- __ __- __ __ __ __ Address: _____
Phone #: (____) _____Employer: _____
Employer's Address: _____
Father's Name: _____ Birth Date: _____
SS#: __ __ __- __ __- __ __ __ __ Address: _____
Phone #: (____) _____Employer: _____
Employer's Address: _____

SUBSCRIBER INFORMATION:
Subscriber's Name: _____Birth Date: _____Sex: ___M___F
Relationship to Patient: _____
Address: _____
Employer: _____ Work Phone #: (____) _____
Employer's Address: _____

INSURANCE INFORMATION:
Insurance Company: _____
Insurance ID #: _____Account/Group #: _____
Clinician patient is seeing today: _____ Effective Date: _____

THIRD PARTY CONSENT
I authorize Broudy and Associates to communicate with my insurance company to coordinate treatment, to facilitate quality of treatment, and obtain reimbursement. By not signing consent, I am agreeing to full payment at the time of service. ***Initial: _____***

**** I understand and agree that, regardless of insurance status, I am responsible for the balance on this account for any professional services rendered. I certify the information provided is true and correct. I will notify Broudy and Associates of any changes in the above information, including insurance coverage, in a timely manner.*** **Initial: _____**

PRIVACY PRACTICE
I acknowledge that I have been provided access to Broudy & Associates Notice of Privacy Practices (NPP). I acknowledge that I can obtain a copy of the full NPP from the front office and/or Broudy & Associates website (broudyassoc.com). If I have any questions regarding the NPP, I will ask to speak with the privacy officer.
Initial: _____

Print Name (parent if patient is a minor): _____

Signature (parent if patient is a minor): _____Date: _____

Patient Name: _____
Patient Date of Birth: _____

NORMAN BROUDY, M.D. & ASSOCIATES
OFFICE POLICIES

• Broudy & Associates requires 24 **business** hours (Monday-Friday) notice for appointment cancellations. Otherwise, the patient may be charged up to the full fee of the appointment and/or terminated from the practice. *For example: if the patient's appointment is on Monday at 9:00am Broudy and Associates must receive a call by 9:00am the previous Friday to have given proper 24 business hour notice.*
Initial: _____

• **First appointments** scheduled with a provider require 48 business hours notice for appointment cancellation/rescheduling. If Broudy and Associates is ***not*** provided 48 business hours notice, the appointment may not be rescheduled.
Initial: _____

• It is the patient's responsibility to know the date and time of his/her appointment. Appointment reminder calls are a courtesy.
Initial: _____

• The office will verify the patient's mental health benefits; however, this is not a guarantee of payment. It is the patient's responsibility to know his/her benefits including deductibles, co-pays and visit limitations. In addition, it is the patient's responsibility to keep track of visits used during his/her benefit year.
Initial: _____

• Insurance companies require payment of co-pays/coinsurance at the time of service. Patient balances not received within 30 days of their visit will be billed and are subject to a $10 processing fee per month.
Initial: _____

• Please notify Broudy & Associates in a timely manner of any changes, including: insurance coverage, address and telephone number. Delay in providing us with accurate insurance information may prevent insurance reimbursement, and the patient will be responsible for fees.
Initial: _____

• Broudy & Associates submits claims *only* to the insurance companies with whom we are contracted.
Initial: _____

• There will be a $30 charge for any returned checks. If there is a history of 2 returned checks, our office will only accept cash or credit card payments.
Initial: _____

As a client of Broudy and Associates, I have read and understand the operating procedures, and hereby give permission to the professional staff at the agency to provide diagnostic and/or therapeutic services.

Signature: _____ Date: _____
(Parent/Guardian if patient is a minor)

Norman Broudy, MD & Associates, LLC
825 Washington Street
Wilmington, DE 19801
(302) 655-7110

I, _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided by Broudy and Associates, a behavioral health provider.

I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to perform within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.

Both parents and/or legal guardian must sign on the below lines if there is a custody agreement in effect.

Signature:_____ Date:_____
Relationship to Patient (if applicable):_____

Signature: _____ Date: _____
Relationship to Patient (if applicable):_____

825 Washington Street
Wilmington, Delaware 19801
302-655-7110

AUTHORIZATION TO DISCLOSE MEDICAL RECORD INFORMATION TO PRIMARY CARE PHYSICIAN AND MENTAL HEALTH THERAPIST

Patients Name: _____

Patient's Date of Birth: _____

I, _____ authorize Norman Broudy, M.D.
(Patient's Name/if minor, Legal Guardian)

And Associates to disclose the following information in order to coordinate treatment: Mental Health, including Alcohol and Substance Abuse to:

Primary Care Physician: _____

Located at the following address: _____

_____

Current Therapist: _____

Located at the following address: _____

_____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.

_____ _____
(Signature of Patient/If minor, Legal Guardian) ***(Date)***

I DO NOT WISH TO AUTHORIZE RELEASE OF INFORMATION

_____ _____
(Signature of Patient/If minor, Legal Guardian) ***(Date)***

The following prohibition may apply:

PROHIBITION OF REDISCLOSURE: This information has been disclosed has been disclosed to you from records where confidentiality is protected by Federal Law. Federal Regulation (42 CFR, part2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations states that any person who violates any provisions of this law shall be fined not more that $500 in the case of the first offense, and not more than $5000 in the case of each subsequent offense.