VIVIAN CHERN SHNAIDMAN, M.D.
Diplomate, American Board of Psychiatry and Neurology and Forensic Psychiatry
10 Vreeland Drive Suite 103, Skillman, NJ 08558

New Patient Form - Please submit via fax (609 964 1700) or email (info@shnaidman.com)			
Last Name:		First name:	Middle Initial:
Today's Date: / /		SSN#:	
Age:	Legal Gender:	Date of birth: / /	
Current address:			
City:	State:	ZIP Code:	
Email:		Receive appointment reminders via email? Yes ☐ No ☐	
		Receive details regarding treatments via email? Yes ☐ No ☐	
Mobile Phone:		May we leave detailed messages on this phone? Yes ☐ No ☐	
Home Phone:		May we leave detailed messages on this phone? Yes ☐ No ☐	
Alternative Phone:		May we leave detailed messages on this phone? Yes ☐ No ☐	
PRIMARY INSURANCE COMPANY:			
PATIENT ID#:		GROUP #:	
Subscriber's Name:		Subscriber's DOB: / /	
Relationship to Insured Patient:			
Subscriber's Address:			
City:	State:	ZIP Code:	
INSURANCE CO. PHONE:			
INSURANCE CO. ADDRESS:			
SECONDARY INSURANCE COMPANY:			
PATIENT ID#:		GROUP #:	
Subscriber's Name:		Subscriber's DOB: / /	
Relationship to Insured Patient:			
Subscriber's Address:			
City:	State:	ZIP Code:	
INSURANCE CO. PHONE:			
INSURANCE CO. ADDRESS:			

RESPONSIBLE PERSON: (Is this information is same as patient? Yes ☐ No ☐ If yes, you may skip this section)		
Name:		
Current Address:		
City:	State:	ZIP Code:
Relationship to Patient:		
EMERGENCY CONTACT:		
Name:		
Phone:		Relationship to Patient:
PRIMARY CARE PHYSICIAN:		
Phone:		
THERAPIST:		
Phone:		Date of last visit:
MEDICAL HISTORY:		
List any medical problems:		
List any hospitalizations (including Psychiatric or Substance Abuse):		

Please list all medications (prescribed or over the counter):

Name of Medicine	Dose	Reason prescribed	Prescribed by	Date started

Food or Drug Allergies:

PSYCHIATRIC HISTORY: Please circle either "No" or "Yes" to the following questions.

Have you ever been given a psychiatric diagnosis? Yes ☐ No ☐ If yes, please describe below.

Have you ever had psychotherapy or counseling in the past? Yes ☐ No ☐ If yes, please describe below.

Have you ever seen a psychiatrist before? Yes ☐ No ☐ If yes, please describe below.

Have you ever attempted suicide or had suicidal thoughts? Yes ☐ No ☐ If yes, please describe below.

Have you ever been the victim of mental, physical, or sexual abuse? Yes ☐ No ☐ If yes, please describe below.

Have you ever had a problem with alcohol or drugs? Yes ☐ No ☐ If yes, please describe below.				
How often do you:				
Smoke	Never O	Monthly O	Weekly O	Daily O
Drink Alcohol	Never O	Monthly O	Weekly O	Daily O
Use Drugs	Never O	Monthly O	Weekly O	Daily O
WHAT ARE YOUR GOALS FOR TREATMENT?				
FAMILY HISTORY:				
Mental Illness? Yes ☐ No ☐ If yes, who, describe:				
Substance Abuse? Yes ☐ No ☐ If yes, who, describe:				
Suicide? Yes ☐ No ☐ If yes, who, describe:				

Credit Card

Everyone must fill in this section. This information is reserved for unresolved charges as described below.

Name on Card:		
Card Number:	Expiration Date:	
Billing Phone:	Code:	
Billing Address:		
City:	State:	ZIP Code:

AGREEMENT

CONFIDENTIALITY

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult,
2. When the patient presents an imminent danger to self,
3. When the patient presents an imminent danger to others,
4. If a judge determines that our discussions are not confidential, a judge may request specific information.

If the patient is a minor, you acknowledge that your child's records are confidential except in the above stated exceptions. Please be aware that submitting mental health claims to your insurance company carries a certain amount of risk to confidentiality, privacy, and the future ability to obtain health or life insurance, or even a job.

INSURANCE

Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Please be aware that not all issues/problems/conditions dealt with in therapy are covered by insurance. It is your responsibility to verify the specifics of your coverage.

We currently submit claims on your behalf if you have **Medicare, Aetna,** or **Blue Cross Blue Shield**. If you have another insurance, you are welcome to see Dr. Shnaidman for treatment, and we will provide you with a bill to submit to your insurance company after you have paid the appointment fees. You are responsible for any applicable deductibles and co-pays at the beginning of each session. You understand that insurance is billed as a courtesy to you and that **you are responsible for full payment if the insurance company denies the claim.**

You also understand that we may stop accepting your insurance in the future, however we will notify you before this change goes into effect.

CANCELLATION

The scheduling of an appointment involves the reservation of time specifically for you. In the event of a "No Show" or failure to give a **full 24-hour notice** of a cancellation, **you will be charged a $50.00 fee.** Please be aware that insurance companies will not cover cancellation charges.

FEES

Fees are listed below for the initial assessment and for individual therapy. Letter writing, consultations with other professionals, telephone conversations, reading records or reports, travel time, longer sessions, etc. will be billed at a rate determined to fit the need. This agreement supersedes all previously agreed to financial agreements and is effective as of the date signed. If your account is overdue (unpaid) and there is no written agreement for a payment plan, I can use legal or other means (court, collection agencies, etc.) to obtain payment.

Patient Fee Schedule

You will be responsible for the following charges, at the time of service unless other arrangements have been made.

Initial evaluation and diagnostic inventory	$395.00
Follow up appointment	$155.00
Medication management (15-20 min.)	$155.00
Missed appointment or Late cancellation (less than 24 hour notice)	$50.00
Returned payments / bounced checks	$50.00
Letters (minimum fee)	$50.00

FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.
PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. **Dr. Vivian Shnaidman** accepts cash, cards, and personal checks. There is a service charge for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality. In such circumstances, we may advise you to seek treatment with a clinic or hospital clinic in your area.

INSURANCE:

We bill appointments participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments- coinsurance at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

If you need assistance or have questions, please contact our office between 9:00 am and 5:00 pm, Monday through Friday at 609-910-1715 or email us at info@shnaidman.com.

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand **Dr. Shnaidman** Financial Policy. I agree to assign insurance benefits to **Dr. Shnaidman's** Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for the cost of collections.

You will be charged $50.00 for every missed or cancelled appointment without 24 hours notice.
If habitually miss or cancel appointments, we have the right to discharge you for non-compliance with treatment.

By initialing here, you acknowledge that you have read the "Financial Policy".

Signature:	Date:

MISCELLANEOUS PROVISIONS

HEADINGS FOR REFERENCE ONLY: The headings preceding the text of the several sections of this Agreement are inserted for convenience and shall not affect the meaning, construction, scope or effect of this Agreement.

CONSTRUCTION OF AGREEMENT

If any provision of this Agreement is held to be invalid or unenforceable, all other provisions shall nevertheless continue in full force and effect.
This Agreement shall be construed and governed in all respects in accordance with the laws of the State of New Jersey.

MODIFICATION

A modification or waiver of any of the provisions of this Agreement shall be effective only if made in writing and executed with the same formality as this Agreement. The failure of either party of insisting upon strict performance of any of the provisions of this Agreement shall not be construed as a waiver of any subsequent default of the same or similar nature.

CONSENT TO EXCHANGE OF INFORMATION FOR TREATMENT AND PAYMENT PURPOSES

I authorize the release and exchange of information between my therapist and the referral source and other co-treating providers for the purpose of treatment, and payment. I also authorize the release of information to my health plan for claims or other health plan purposes. Your signature below indicates that you give Dr. Shnaidman your consent for treatment.

Patient's Signature:	Date:
Patient's Printed Name:	Date:
Responsible Party's Signature: (if applicable)	Date:
Responsible Party's Printed Name: (if applicable)	Date:

Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

I want you to know that I respect the privacy of your personal medical records and will do all I can to secure and protect that privacy. I strive to always take reasonable precautions to protect your privacy. When appropriate, I provide the minimum necessary information to only those I feel are in need of your health care information. This includes information about treatment, payment, and/or health care operations in order to provide health care that is in your best interest.

I also want you to know that I support appropriate access to medical records. With your consent, I may disclose personal health information for purposes of treatment, payment, or health care operations such as communication with hospitals, co-treaters, and health plans.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, if you refuse to disclose your personal health information, I have the right to refuse to treat you. If you choose to give consent in this document, at some future time you may request to refuse to disclose all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You may request a restriction on any authorization to disclose personal health information. I am not required to agree with this restriction request. You have the right to have me amend your protected health information. If the request is denied, you may file a disagreement with me and prepare a rebuttal, which will be added to your personal health information. You have a right to receive an accounting of disclosures of your health information I have made, except that I do not have to account for the disclosures provided to you or pursuant to your written authorization, or as described herein regarding treatment, payment, health care operations, notification and communication with family, and specialized government functions, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

We will not use or disclose your therapy notes without your prior written authorization except for the following: use by the originator of the notes for your treatment, for training our staff, students and other trainees, to defend ourselves if you sue us or bring some other legal proceeding, if the law requires us to disclose the information, in response to health oversight activities concerning your therapist, to avert a serious and imminent threat to health or safety, or to the coroner or medical examiner as appropriate.

I want you to know that I continually undergo training to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." I strive to achieve the very highest standards of ethics and integrity in providing services to my patients.

If you have any questions or problems, please speak with me directly, as I welcome your feedback. You may also file a complaint with the Secretary of Health and Human Services if you believe that I have violated your privacy rights.

By initialing here, you acknowledge that you have received a copy of the "Notice of Privacy Practices".

Signature:	Date:

VIVIAN CHERN SHNAIDMAN, M.D.
Diplomate, American Board of Psychiatry and Neurology and Forensic Psychiatry
10 Vreeland Drive Suite 103, Skillman, NJ 08558

Please fill this out if you would like us to contact your therapist, family member, etc.

At the request of the individual, I, _____, hereby authorize the release and re-disclosure, via paper, email, fax, or verbal/telephone communication, of any and

☐ all medical, psychiatric, and psychological records;

☐ any drug and alcohol abuse treatment information; and

☐ any HIV/AIDS information kept by:

Vivian Chern Shnaidman M.D.
10 Vreeland Drive Suite # 103
Skillman, NJ 08558
Phone: 609-910-1715
Fax: 609-964-1700

To:

_____
_____
_____
_____
_____

Phone: _____

Fax: _____

_____

Name (Print) Signature Date

_____

Witness Name (Print) Signature Date

_____

Parent or Legal Guardian (Print) Signature Date

Authorization is subject to revocation at any time by the patient unless the provider has already relied upon it. Authorization will expire in accordance with our record retention policy. For activities covered by HIPAA, I do not condition treatment, payment, enrollment, or eligibility for benefits on this authorization.