MedicalCounseling

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~ Welcome to MedicalCounseling. Please print the information requested below. Thank you. ~

NEW PATIENT REGISTRATION

Name_____Today's Date: _____

Address: _____
Street Apt. # City State Zip Code

Phone: Home ( ) _____ Cell ( ) _____ Work ( ) _____

Contact preference: ☐ Home ☐ Cell ☐ Work Okay to leave a message? ☐ Yes ☐ No

E-mail*: _____ Okay to send email message (non-confidential)? ☐ Yes ☐ No
*Not secure for your personal health information.

Birth date: ___/___ /_____ Age: _____ Gender: ☐ M ☐ F ☐ Other _____

Employer: _____ Occupation: _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Primary Care Physician: _____Phone: ( ) _____

Please list any other Physicians/Healthcare Practitioners you are seeing at this time (both standard and alternative):

Name & specialty: _____ Phone: ( ) _____
(Please use the reverse side for additional practitioners)

Referred by (name): _____
☐ Family Member ☐ Friend ☐ Brochure ☐ Web site ☐ Other (Specify: e.g., M.D., chiropractor, therapist, etc.)

Primary Insurance: _____ Subscriber ID#: _____

Secondary Insurance: _____ Subscriber ID#: _____

Subscriber's name: _____ Birth date: ___/___ /_____ Group #: _____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Other _____

Do you need billing statements to send to your insurance company for reimbursement? Yes___ No___
Would you like billing statements (with diagnosis and visit codes) sent via:
☐ Mail Yes___ No___ ☐ E-mail (non-secure, see below about e-mail) Yes___ No___

IN CASE OF EMERGENCY

Name of local friend or relative: _____ Relationship: _____

Home: ( ) _____Cell: ( ) _____Work: ( ) _____

Important Information — Please Read Carefully

How to contact me:
I am available by cell phone at 510-701-0134 and pick up my messages regularly. Please call between the hours of 9:30 a.m. and 8:00 p.m. unless it is urgent.

In an emergency:
Call 911, go to the nearest hospital emergency room, or call: Alameda County Crisis Hotline, 1-800-309-2131.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE FOLLOWING POLICIES:

Consent to treatment and fees:
I understand that I am consenting to Medical Counseling treatment by Danielle Rosenman, M.D. and agree to pay all charges at the time of service. Checks and cash preferred, credit cards accepted. I will be responsible for $15.00 plus bank charges if my check does not clear. If payment of my account is over 60 days late, or it goes to collection, all fees including collection, attorney fees, and applicable finance charges will be my responsibility. I hereby authorize the release of any information necessary for payment of charges incurred.

There is a fee of $25–$50 to copy medical records or complete certain forms, depending on how long it takes.

Canceled appointments:
I understand that 24 hours' notification is required to cancel an appointment; otherwise, I will be charged the full fee.
I must **call or text Dr. Rosenman (510-701-0134) no later than 12 noon the day before the appointment,** or be charged. E-mail cannot be used to cancel appointments any later than 2 days before the appointment.

Fragrance-free office:
I have been requested not to wear scented products (lotions, perfumes, hair products, aftershave, deodorants, and others) to the office, in order to protect those with allergies.

Privacy Practices and E-mail:
I have read the **Notice of Privacy Practices** for this office. Copies are available to view on the Web site, www.medicalcounseling.net, as well as available on request via e-mail or hard copy at the office.

Because nonencrypted e-mail sent via the Internet may be intercepted by third parties or transmitted to unintended parties, privacy of personal health information cannot be assured. There can be delays in responding to e-mail, and it must never be used to communicate problems or emergencies. ***I have been advised by Dr. Rosenman not to use Internet-based communication, including e-mail and the form on the Web site (which are nonencrypted), to discuss my private health information.*** **She is available by phone and at office visits to discuss personal information confidentially.** I can choose to receive e-mail for non-private communication such as scheduling office visits or exchanging non-personal information, or receiving invoices, by checking the box on the registration form. **I have the option to schedule appointments via phone and to receive invoices via mail.** If, despite Dr. Rosenman's advice, I choose to send personal health information by e-mail, she is not liable for any breach of privacy that could occur.

Signature: _____ Date: ____/____ /_____