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:

DŽƚŚĞƌ͛ƐEĂŵĞ͗ ͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺ ŝƌƚŚĂƚĞ͗ ͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺ

SS#: \_\_ \_\_ \_\_- \_\_ \_\_- \_\_ \_\_ \_\_ \_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ŵƉůŽǇĞƌ͛Ɛ ĚĚƌĞƐƐ͗ ͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺͺ

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SS#: \_\_ \_\_ \_\_- \_\_ \_\_- \_\_ \_\_ \_\_ \_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SUBSCRIBER INFORMATION:

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Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_

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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. )RU H[DPSOH LI WKH SDWLHQW¶V 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 psychiatrist or a nurse practioner 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: \_\_\_\_\_\_\_

,W LVWKH SDWLHQW¶VUHVSRQVLELOLW\ WR know the date and time of his/her appointment. Appointment reminder calls are a

courtesy.

Initial: \_\_\_\_\_\_\_\_

 7KH RIILFH ZLOO YHULI\ WKH SDWLHQW¶V PHQWDO KHDOWK EHQHILWV‑ Kowever, this is not a guarantee of payment. It is the patienW¶V

responsibility to know his/her benefitsincluding deductibles, co-SD\V DQG YLVLW OLPLWDWLRQV ,Q DGGLWLRQ LW LVWKH SDWLHQW¶V

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 & Associatesin 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: \_\_\_\_\_\_\_\_

 %URXG\ $VVRFLDWHV ZLOO QRWVXEPLW FODLPVWR VHFRQGDU\ LQVXUDQFHV ZLWK WKH H[FHSWLRQ RI '3&,   
0HGLFDid) and

Medicare supplemental plans.

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)