NEW YORK MEDICAL BEHAVIORAL HEALTH, PC

890 WESTFALL ROAD, SUITE B

ROCHESTER, NY 14618

(585): 442-6960 FAX: (585) 442-3548

Please note that your appointment may be delayed for 30 to 45 minutes despite our best effort to stay on time

On the day of scheduled visit, please come 15 to 30 minutes early. You may have paperwork to fill out. Your cooperation is greatly appreciated.

Section I: Patient Information Date_____

Name: _____ I prefer to be called: _____

Address: _____City:_____State:_____Zip_____

Phone (___) _____ Work Phone (___) _____ Cell Phone (____) _____

The best time to contact me is: ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth: _____ Social Security Number (Optional): _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_____ City/State_____☐ FT ☐ PT

Spouse or Parent's Name: _____

Employer_____ Work Phone_____

Who referred you? _____

Person to contact in case of emergency_____
Phone_____

Email Address: _____Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II Financially Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Employer_____ Work Phone (____) _____

TURN OVER

Section III Insurance Information

Name of Insured _____DOB_____ Relationship to Patient _____
Name of Employer: _____ Work Phone: (____) _____

Address of Employer: _____City_____ State: ____Zip _____

Insurance Company_____ Group #_____

Subscriber's ID#_____ Insurance Phone: _____

Subscriber's Name: _____ DOB_____

DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured _____DOB _____Relationship to Patient _____

Name of Employer: _____ Work Phone: (____) _____

Address of Employer: _____City_____State:____Zip _____

Insurance Company_____ Group #_____

Subscriber's ID#_____ Insurance Phone: _____

Subscriber's Name: _____ DOB_____

INSURANCE AND REFERRALS:	I understand that it is **MY RESPONSIBILITY** to call my insurance company to verify that Dr. Chaudhri is a provider for my insurance plan. I also understand that it is **MY RESPONSIBILITY** to obtain a referral when required by my insurance company. If I have called verified Dr. Chaudhri is a provider or do not have a referral in place at the time of service I will be responsible for the **ENTIRE FEE** for the services provided.
PAYMENT:	I understand that full payment is expected at the time of each appointment.
CANCELLATIONS:	I understand that there will be a **full charge for any visit not cancelled 24 hours in advance**. I understand that this fee is my responsibility and cannot be billed to my insurance.
AUTHORIZATION:	I give the permission to New York Medical Behavioral Health, PC and its staff to contact and share information, written or verbal related to my psychiatric care. ☐ Insurance ☐ Pharmacies ☐ Disability Insurance ☐ Worker's Compensation Insurance ☐ No-Fault Insurance ☐ Neuronetics Inc (TMS vendor), business and legal associates

_____ _____

Signature Date