Lisa Karabelnik, MD
Child, Adolescent, and Adult Psychiatrist
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PATIENT INFORMATION FORM

Date: _______________

Patient's Name: ________________________________ Home Phone: _______________________

Date of Birth: ______________________ Sex: M F

Address: ____

Allergies:____

School (If applicable):____ Grade: _______

Address: ____

Phone: _____________________ Fax: _____________________ Teacher: _______________

Primary Care Physician: ____

Address: ____

Phone: ___________________________________ Fax: _________________________________

Therapist: ____

Address: ____

Phone: ___________________________________ Fax: __________________________________

Parent's Name: ____ (H) ______________________

Address: ____ (W) _____________________

DOB: ____ (Cell) ____________________

Email:____

Parent's Name: ____ (H) ______________________

Address: ____ (W) _____________________

DOB: ____ (Cell) ___________________

Email: ____

Emergency Contact: ____ Phone: ___________________

Who has <u>legal</u> custody of the patient? ____

Step-Parent's Name (if applicable) ____

(H)___________________ (W) ________________________ (Cell) _______________________

Referred by: ____

PHARMACY:____ Number:__________________________

Address: ____Fax: _______________________________

PLEASE FILL OUT INSURANCE INFORMATION (Though I do not take insurance, if a prior authorization is required, I need your insurance information in order to obtain it.)

INSURANCE INFORMATION

Insurance Company Name and Mailing Address:

____

____

Phone number for Mental Health Benefits: ____

Phone number for Pharmacy Benefits: ____

POLICY HOLDER: ______________________ RELATIONSHIP TO PATIENT: ______________

Address: ____

Home__________________Work__________________Policy Holder's Date of Birth______________

ID Number _________________________Group Number ___________________________________

Pharmacy Benefit Company/ID number: ____ Is this coverage through your employer? Yes No

AUTHORIZATION OF RELEASE:

I hereby authorize Lisa Karabelnik, MD to provide information requested by insurance companies with whom I have the coverage in order to process insurance benefits (if needed) if I choose to seek out of network benefits and file with my insurance carrier on my own. Such information may also be requested to process prior authorizations.

________________________________ ___________________ ________________

Responsible Party Signature Relationship Date

PAYMENT:

I accept responsibility to pay all fees for services rendered by Lisa Karabelnik, MD. Full payment is expected at the time of service. I understand that my appointment time is reserved for me and that there will be a charge for appointments broken or cancelled with less than 24 hours notice. I understand that I can submit the receipt supplied by Dr. Karabelnik to the insurance company for reimbursement.

____ _____________________

Signature of Parent/Legal Guardian or Patient if over 18 Date

HIPPA CONSENT

Confidentiality of sessions will be maintained except under certain circumstances required by law (i.e. imminent danger to yourself or others, suspected emotional, physical, or sexual abuse of children, upon receipt of a legitimate subpoena, or in the event of a medical emergency), or unless I authorize communication about me (my child's) treatment with a release of information form.

My signature below indicates my agreement to the terms of treatment and acknowledges that Dr. Karabelnik has offered me a copy of the HIPPA documentation and talked about the concept of protected health information with me.

______________________________ ___________________ _________________

Responsible Party Signature Relationship Date