REGISTRATION FORM

Please print or write clearly

Patient's Last Name _____ First Name _____ M.I. _____

Date of Birth: (mm/dd/yyyy): _____

Marital status ☐single ☐married ☐divorced ☐ widowed

Contact Information

Home Address _____

_____

_____

Cell phone number: (____) ____ - _____ I agree to received SMS messages from Guy Farber MD and Dr. Guy Farber's office to this cell phone number ? ☐Yes ☐No

Home phone number (____) ____ - _____

Email: _____

Insurance Information (please attach copy of front and back of insurance cards with this form)

Primary Insurance Information

Insurance Name: _____

Insurance ID#: _____ Group ID: _____

Insur**ed**'s first name: _____ last name _____Insured's Date of Birth ___/___/_____

Relationship to Insured ☐self ☐spouse ☐child ☐other: _____

Insured's Employer: _____

Phone number for **PROVIDERS** given on the back of the insurance card: ( ) _____ - _____

Secondary Insurance Information

Insurance Name: _____

Insurance ID#: _____ Group ID: _____

Insured's Name: _____ Insured's Date of Birth _____/___/_____

Relationship to Insured_____

Insured's Employer: _____ Insurance ID#: _____

Phone number for **PROVIDERS** given on the back of the insurance card: ( ) _____ - _____

General Consent For Treatment

I, _____, hereby consent to and authorize Dr. Farber and/or his designees (hereinafter the "Practitioners") to evaluate my medical condition and conduct any routine and non-invasive diagnostic and therapeutic procedures and treatments, which in the Practitioners' judgment are necessary for my care. I understand that I have a right to refuse any recommended treatment once it has been explained to me.

Signature of Patient or authorized representative _____ Date ___ / __ /_____

Consent For Release of Information to Insurance Companies and Third-Party Payors (this authorizes Dr. Farber bill your insurance company)

I hereby authorize the Practitioners, having treated me, to release to governmental agencies, insurance carriers and/or others who are financially liable for my medical care, all information needed to substantiate payment for such care, including but not limited to information regarding substance abuse and/or dependence, and to permit representatives thereof to examine and make copies of all records relating to such treatment to the extent necessary to process claims.

Signature of Patient or authorized representative _____ Date ___ / __ /_____

I give my consent for Dr. Farber to obtain, if available, the medication history from pharmacy records

Signature of Patient or authorized representative _____ Date ___ / __ /_____

Assignment of Benefits to the Practitioners (if you pay for the services with Dr. Farber and have the insurance reimburse you, this section is not needed. Otherwise please sign this so you can pay any copays, and the insurance company can pay Dr. Farber for the services directly)

I hereby assign, transfer and set over to the Practitioners sufficient monies and benefits to which I may be entitled from governmental agencies, insurance carriers and/or others who are financially liable for medical care to cover the costs of the care rendered to me or my dependent by the Practitioners.

Signature of Patient or authorized representative _____ Date ___ / __ /_____

Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made either to me or on my behalf to Dr. Farber. I assign the benefits payable for physician services to the Practitioners and authorize such Practitioners to submit a claim to Medicare for payment for such services.

Signature of Patient or authorized representative _____ Date ___ / __ /_____

Financial Responsibility / Guarantee of Payment (this section means that you are responsible for the payment of the services you received by Dr. Farber)

For, and in consideration of, services rendered or to be rendered by Practitioners, I herby guarantee payment of any bills for such services.

Signature of Patient or authorized representative _____ Date ___ / __ /_____

Late Cancellation Policy

Dr. Farber strives to spend plenty of time with you on your visits, and for you to avoid long waiting time in the waiting area prior to your visit, and therefore no double-booking is done. As often there are patients on the waiting list, please be considerate of other patients and let Dr. Farber and his staff know of any appointment cancellation as soon as possible by calling or sending a text message to our office number (516) 714 5098 or via vSee. I understand that if I do not notify Dr. Guy A. Farber at least 3 business days (72 hours) in advance of the scheduled time of my appointment of any request for cancellation or change of the time of the appointment, I will be responsible for a **$50** late-cancellation fee. I also understand the rest of the office policies available at http://www.guyfarbermd.com/policies.html

Signature of Patient or authorized representative _____ Date ___ / __ /_____

Notice of Privacy Practices

Dr. Farber's privacy practices are available at www.GuyFarberMD.com/NoticeOfPrivacyPractices.pdf

Keeping patient's credit card on file

Your credit card information would be stored securely electronically in the billing software (AdvancedMD secure servers), and processed by our credit card processing company OpenEdge, a division of GobalPayments company, in a fully secured, encrypted, PCI compliant fashion. You can visit www.openedgepayment.com to learn more about OpenEdge.

I have read the above, and I agree that Dr. Farber and his staff would keep my credit card on file, and would automatically bill my credit card for my patient's responsibility portion as determined by my insurance company (e.g. my regular copay for each visit). I also agree that my credit card be charged $50 for a late cancellation fee or if I don't show up for my scheduled appointment.

Signature: _____ Date: _____

Please use additional sheet of paper if needed. Please print or type clearly.

Who referred you to Dr. Farber? _____

Please describe the nature of the problem/problems that you would like Dr. Farber to help you with:

_____

_____

_____

_____

_____

Please list any medical problems that you had or currently have (for example high blood pressure):

_____

_____

_____

_____

_____

Please list all medications that you are taking, including ones that you take occasionally on "as needed bases" such as Xanax or Percocet) including over the counter medications. Please specify the dose of each of the medications and how many times a day you take it (or attached a complete medication list)

_____

_____

_____

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_____

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_____

_____

_____

_____

Have you ever been treated by a psychiatrist before? ☐No ☐Yes
Is so, what was your prior diagnosis? _____

_____

_____

Please list **ALL** psychiatric medications you have taken in the **past**. Your pharmacy may be able to give you some of this information. Any information you provide may help Dr. Farber recommend the most appropriate treatment options for you. Use additional sheet of paper if necessary.

Name of Medication	Highest dose prescribed	Duration took the highest dose	Any side effects of the medication	How helpful was this medication

Do you have any allergies to medications? □No □Yes
If you do, Please list ALL drug allergies: the drug name, the type of reaction, and the severity of the reaction (mild/moderate/severe)

Drug name: _____ Reaction: _____ Severity: □low □moderate □severe

Drug name: _____ Reaction: _____ Severity: □low □moderate □severe

Drug name: _____ Reaction: _____ Severity: □low □moderate □severe

Drug name: _____ Reaction: _____ Severity: □low □moderate □severe

Have you ever been in psychotherapy before? □No □Yes

If so:

Name of Therapist	Approximate year of treatment	How long were you in Therapy?	Was therapy helpful?

Have you ever been admitted to a psychiatric hospital? ☐No ☐Yes
If so:

Hospital Name	Approximate year of admission	Reason for admission and Diagnosis

In the past **1 year:**
1. Did you smoke/vape tobacco? ☐No ☐Yes. If yes how much and how often _____
2. Did you smoke/vape cannabis? ☐No ☐Yes. If yes how much and how often _____
3. Did you take any opioids? ☐No ☐Yes. If yes how much and how often _____
4. Did you use any cocaine? ☐No ☐Yes. If yes how much and how often _____
5. How many alcoholic drinks do you have /week on average: _____
6. Did you use any other recreational drugs? ☐No ☐Yes. If yes, which ones, how much and how often
_____

Do you have any history of substance abuse/dependence? ☐No ☐Yes; if so, please describe:
_____
_____
_____

Have you even been treated for an alcohol or drug problem? ☐No ☐Yes

- What is your height? _____
- What is your current weight? _____

What pharmacy would you like to use to receive any prescriptions?

- Pharmacy name _____
- Pharmacy address (please include zip) _____

Background Information:

Place of birth: _____

Have you been diagnosed with a learning disability or ADHD? ☐ No ☐ Yes

If so, please describe: _____

_____

If you had any higher education, please describe:

_____

_____

Do you have any hobbies? What activities do you enjoy doing?

_____

_____

Do you practice any religion? ☐No ☐Yes If so, which one? _____

Please describe your marital history: (How many times have you been married if any, for how long?)

_____

_____

Are you currently in a relationship? ☐No ☐Yes If so, for how long? _____

How is your relationship with your partner? _____

Please list the first names of your children and their approximate ages:

_____

Whom do you currently live with? _____

Current employer: _____

What is it that your do at your current job _____

Do you have any firearms? _____

Please list all your relatives (that you know) that have any mental health problems or substance abuse problems (for example: depression, anxiety, bipolar disorder, schizophrenia, panic disorder, PTSD). Please list each person separately: for example: mother's brother with depression and alcohol problem, grandmother from my mother's side with social phobia):

_____

_____

_____

- Please send with this registration from a copy of your most recent labs, or ask your primary care doctor to fax it to Dr. Farber's office at 516 714 5096
- Please send with this registration a copy of any photo ID (e.g. license)