1085 Park Avenue, Suite 1E
New York, NY 10128
Office: (646) 661-7447
Fax: (800) 762-7636
Info@DrStevenG.com

ADULT PATIENT INTAKE FORM

Please fill out the below form and email or fax it to us 24 hours prior to your appointment.

Name of Patient: ____Date: _____________________________________

E-mail: ____

Address: ____ Apt: ___________________

City: ________________________________ State: ______________________________ Zip: ___________________

Phone: _______________________________ Cell: _______________________________ DOB: _________________

Do we have your permission to communicate your health information via email? ☐ Yes ☐ No

☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: ____

How did you hear about our clinic? ____

Emergency Contact: ____________________________ Phone: _________________ Relationship: _________________

READINESS ASSESSMENT

Please rate the following questions on a scale of 1-10: 10 = VERY important, VERY prepared etc)

________ **How important is it for you to resolve your health concerns now rather than later?**
________ **How prepared are you to make lifestyle and diet changes that are necessary to achieve your goals?**
________ **Are you coachable and willing to work with a mentor to help you?**

What kind of “student” would you describe yourself to be?

☐ I am an “A” student: I will do everything you say, as you say, when you say it!

☐ I am a “B” student: I know I need to get better and I am motivated, but I might make some mistakes along the way and will need your help (most of our clients are B students!)

☐ I am a “C” student: My health is not really that important to me and I am not truly motivated to change

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Patient Health Information and Privacy Policy
This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: Final Rule as seen in Federal Register 2/20/2003

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.

2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.

3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.

4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.

5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.

6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Financial Obligation and Appointment Policy
The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Payment in full is required for all services rendered at the time of visit. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

Informed Consent Regarding Email
Dr. Steven Geanopulos provides patients the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
   a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.
   b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e----mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their email.

2. It is the policy of Dr. Steven Geanopulos that all e-mail messages sent, or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient’s protected personal health information and will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. Dr. Steven Geanopulos will use reasonable means to protect the security and confidentiality of e-mail, or Internet communication. Because of the risks outlined above, we cannot; however, guarantee the security and confidentiality of e-mail, or Internet communications.

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mail to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, Dr. Steven Geanopulos' physicians, nurses, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
b. Dr. Steven Geanopulos may forward e-mail messages within the practice as necessary for diagnosis and treatment. Dr. Steven Geanopulos will not; however, forward the e-mail outside the practice without the consent of the patient as required by law.
c. Dr. Steven Geanopulos will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, **e-mail must not be used in a medical emergency**.
d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
e. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.
f. Dr. Steven Geanopulos cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or Internet, communication, but Dr. Steven Geanopulos not liable for improper disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.
g. If consent is given for the use of e-mail, it is the responsibility of the patient to inform Dr. Steven Geanopulos of any type of information you do not want to be sent by email.
h. It is the responsibility of the patient to protect their password, or other means of access to e----mail sent, or received from Dr. Steven Geanopulos, to protect confidentiality. Dr. Steven Geanopulos is not liable for breaches of confidentiality caused by the patient. Any further use of e----mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to Dr. Steven Geanopulos. I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

By signing below I affirm that I have read and accept the following prior disclosures:

☐ Consent to professional treatment
☐ Patient health information and privacy policy
☐ Financial obligations and appointment policy
☐ Informed consent regarding email

Print Name: ____

Signature: ____

Date: ____