Steven Rosenzweig, M.D.
123 Chestnut Street; Suite 204; Philadelphia, PA 19106
Tel: 215-627-3782
Email: staff@stevenrosenzweigmd.net
Web: www.stevenrosenzweigmd.net

Today's date:		
Patient Name		Date of Birth
Address		
Best phone contact number: ☐ Cell ☐ Home ☐ Work	Alternative contact number: ☐ Cell ☐ Home ☐ Work	
Emergency contact – Name:	Relationship:	Phone number:

PRIVACY POLICY

NOTICE OF PRIVACY PRACTICES

☐ I received and reviewed a copy of the Notice of Privacy Practices

☐ No thanks: I don't need to receive or review a copy of the Notice of Privacy Practices

EMAIL

☐ I give permission for my email to be used for appointment scheduling and reminders.

☐ I give permission for I give permission for Dr. Rosenzweig and his staff to correspond with me by email about my health information. We make every effort to protect the confidentiality of all email correspondence. Email is a convenience but is optional.

Email address:

PERMISSION FOR DR. ROSENZWEIG TO DISCLOSE HEALTH INFORMATION

1. Your referring physician. If you required a physician referral for insurance purposes, Dr. Rosenzweig must send a report back to the referring physician. You may refuse this, but we would not be able to bill insurance for your visit.

2. Your other current treating physicians / therapists. It is often important for Dr. Rosenzweig to send a report to another physician who is actively treating you.

☐ Yes, Dr. Rosenzweig may send a report to any of my current physicians or therapists.

☐ No, Dr. Rosenzweig should only send my information to the following physicians or therapists:

3. I give consent to Dr. Rosenzweig and his staff to discuss my medical information with the following family members, friends, or health advocates:

X_____

Signature of Patient or Authorized Health Representative Date

Patient name: _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Company:	Company:
ID# Group #	ID# Group #
Name of policy holder	Name of policy holder
Relation to patient	Relation to patient

INSURANCE REFERRAL TO BE SEEN BY DR ROSENZWEIG

☐ My insurance plan does not require a referral or prior authorization to be seen

☐ A copy of my referral has been provided

FINANCIAL RESPONSIBILITY

Name of Person Responsible for Payments: _____

Relationship to Patient:

Address and Phone Number (if different from above):

Patients are responsible for obtaining referrals if required by their insurance plan. This must be done by the time of the office visit. Otherwise we will need to bill you directly.

Patients are responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service.

Patients may be responsible for additional charges not covered by insurance:

- Charge for missed appointments without 1 complete business day advance notice: $150 for missed initial visit; $75 for missed follow-up visit.
- Charge for returned checks
- Charge to established patients for extensive phone consultations (>10 minutes) or after-hours phone calls requiring diagnosis and treatment (>10 minutes). These phone contacts are not covered by insurance plans and are billed after the first 10 minutes at a prorated, hourly rate
- Charge for the copying and distribution of patient medical records
- Laboratory and other testing – Patients are responsible for verifying their own insurance coverage for any testing ordered by Dr. Rosenzweig.

AUTHORIZATION AND RELEASE

I authorize release of any information concerning my (this patient's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise provided to me directly to Dr. Rosenzweig for his services

X Signature of Patient or Guardian: Date:

Patient's Authorization For Dr. Rosenzweig to Disclose Protected Health Information

Patient's Name: **Date of Birth:**

I authorize the practice of Steven Rosenzweig, MD to disclose my health information as described below.

Check as appropriate:

☐ INCLUDE / ☐ DO **NOT** INCLUDE: any and all psychological and psychiatric information (separate authorization is required for psychotherapy notes)

☐ INCLUDE / ☐ DO **NOT** INCLUDE: any and all drug and alcohol treatment information

☐ INCLUDE / ☐ DO **NOT** INCLUDE: any and all HIV/AIDS related treatment information

☐ INCLUDE / ☐ DO **NOT** INCLUDE: any and all genetic information

NAME OF PHYSICIAN, INDIVIDUAL OR ENTITY	TYPE AND AMOUNT OF INFORMATION (e.g. Progress notes, test results, outside reports)

I understand that if I give permission, I have the right to change my mind and revoke it in writing.

I also understand that any disclosures already made with my permission cannot be taken back. By signing this Authorization, I understand that any disclosure of information carries the potential for an unauthorized re-disclosure not protected by Federal privacy rules.

SIGNATURE OF PATIENT OR AUTHORIZED HEALTH REPRESENTATIVE **DATE**

Authorized Health Representative's Name **Relation to Patient**

Steven Rosenzweig, M.D.

New Patient Intake Form

Visit Date:

Patient Name: **Date of Birth:**

Current Gender Identity:

Reason for Consultation. Please list the major issue(s) here:

Referred by:

Past Medical History. Please list all medical conditions, diagnoses, or medical problems for which you have been treated.

Past Surgical History. Please list all major surgeries with dates:

Past Major Physical Injuries with dates:

Healthcare Team.

Name of your Primary Care Provider:

Other key physicians / healthcare providers who treat you:

Allergies.

Medication(s) and nature of reaction:

Other (food, environmental, etc) and nature of reaction

Medications – List ALL Prescription and Over-the-Counter or attach list. Please include doses.

Supplements / Herbal Medicines / Homeopathics – list here or attach list. Please include doses.

Advance Directive

Have you appointed a health care proxy (given someone medical power of attorney)? Name of proxy:

Do you have a living will?

Do you need more information about advance directives?

Patient Name:_____

Family Medical History. Medical problems of your family members (including cancer, early heart disease, high blood pressure, diabetes)?

Father:	Child:
Mother:	Child:
Brother:	Other:
Sister:	Other:

Social History and Lifestyle Inventory: <u>Skip any questions</u> you feel uncomfortable about answering.

Tobacco: Present use? Past use?

Alcohol: How many alcoholic beverages to you drink per week?

Significant use of recreational drugs?

Past or present chemical dependencies?

Diet: Do you adhere to a particular diet? Do you avoid certain foods? Do you have any eating problems or restrictions?

Tell about your daily routine, work, studies, responsibilities, interests:

With whom do you live? Is your living situation safe and wholesome?

Exercise – type, intensity and frequency:

Mind body practices (meditation, yoga, Tai Qi, prayer, etc.):

Other wellness practices – what else do you do to support your health and well-being?

Major life stressors and challenges:

Do you have a good social support or family, friends or neighbors?

What gives your life meaning? How close to your life purpose are you living?

What else would it be helpful for Dr. Rosenzweig to know about you?

Patient Name:_____

Symptom Review – Please check off any **CURRENT** symptoms

Note: Some items ask you to rank your symptoms on scale of 0 (nothing) to 10 (most extreme imaginable).

General	
Diminished wellbeing (circle score)	0-1-2-3-4-5-6-7-8-9-10
Fatigue/tiredness (circle score)	0-1-2-3-4-5-6-7-8-9-10
Drowsiness (circle score)	0-1-2-3-4-5-6-7-8-9-10
Sleep: Problem falling asleep	☐
Sleep: Problem staying asleep	☐
Unexplained weight loss or gain	☐
Pain	
Pain severity now (circle score)	0-1-2-3-4-5-6-7-8-9-10
Average past week (circle score)	0-1-2-3-4-5-6-7-8-9-10
Maximum severity past week:	0-1-2-3-4-5-6-7-8-9-10
Eyes	
Blurry vision	☐
Dry eyes	☐
Ears / Nose / Throat / Sinuses	
Ringing in ears	☐
Sinus infections	☐
Other	☐
Heart / Circulation	
Palpitations or irregular pulse	☐
Chest discomfort with exercise or exertion	☐
Leg swelling	☐
Lungs	
Shortness of breath (circle score)	0-1-2-3-4-5-6-7-8-9-10
Wheezing	☐
Other:	☐
Digestion / Elimination	
Loss of appetite (circle score)	0-1-2-3-4-5-6-7-8-9-10
Nausea (circle score)	0-1-2-3-4-5-6-7-8-9-10
Abdominal pain / cramps	☐
Abdominal bloating	☐
Excessive belching or flatus	☐
Constipation	☐
Diarrhea	☐
Bladder / Kidneys / Urination	
Frequent urine infections	☐
Urination difficulties (pain, urgency)	☐
Sexuality	
Sexuality issues to discuss with physician?	☐

Gynecological	
Abnormal menstruation	☐
Severe premenstrual symptoms	☐
Muscles / Bones / Joints	
Muscle cramps or spasms	☐
Joint pain / stiffness / swelling	☐
Nervous system	
Headaches	☐
Numbness or burning or shooting pain	☐
Difficulty concentrating or remembering	
Other	☐
Allergies / Immune System	
Seasonal allergies	☐
Chemical allergies	☐
Frequent infections	☐
Hormonal / Endocrine	
Cold intolerance	☐
Heat intolerance	☐
Excessive thirst	☐
Excessive hunger	☐
Eyebrow hair loss	☐
Blood (Hematologic)	
Abnormal bruising	☐
Abnormal bleeding	☐
Skin	
Rashes	☐
Eczema	☐
Other	☐
Psychiatry/ Psychology	
Anxiety/restlessness: (circle score)	0-1-2-3-4-5-6-7-8-9-10
Depressed / sad: (circle score)	0-1-2-3-4-5-6-7-8-9-10
Other	
Anything else?	

Thank you!

Patient's Authorization to Disclose Protected Health Information to the Practice of Dr. Rosenzweig

Patient's Name:	**Date of Birth:**

I authorize the following practice(s) to disclose my health information as described below to

Steven Rosenzweig, MD
123 Chestnut Street; Philadelphia, PA 19106
Fax: 888-802-0516; Tel: 215-627-3782

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