NORMAN LEE M.D. LLC

Email: NormanLeeMD@NormanLeeMD.com
Tel: 646-535-8826
Fax: 646-219-0961
www.NormanLeeMD.com

Psychiatric Intake Form

(All information on this form is strictly confidential)

Name: ______________________________ Birthdate: ___________

Address: ______________________________

Cell Phone: ____________________ Other Phone: ___________________ Email: ______________________________

How did you find Dr. Norman Lee (for example: professional referral, ZocDoc, internet search, etc)?

____

____

Why are you seeking a consultation/appointment (for example: depression, anxiety, medication management, therapy, etc)?

____

____

Your Medical History:

Allergies: ______________________________ Weight: __________Height: ____________

List ALL current **prescription** medications and how often you take them (if none, write none):

Name	*Dose*	*Frequency*	*Name*	*Dose*	*Frequency*
Hydrochlorothiazide	25mg Tablet	In the Morning	Metformin	500mg Table	Twice a Day

Current **over-the-counter** medications or supplements:

____

____

Current medical problems (please √ check mark the relevant conditions):

Thyroid Disease	☐	Fibromyalgia	☐
Anemia	☐	Heart Disease	☐
Liver Disease	☐	Seizures	☐
Chronic Fatigue	☐	Chronic Pain	☐
Kidney Disease	☐	High Cholesterol	☐
Diabetes	☐	High Blood Pressure	☐
Asthma	☐	Head Trauma	☐
Stomach or Intestinal Problems	☐	Liver Problems	☐
Cancer: ___________________	☐		

Any other medical problems (please describe):

____

____

____

Have you ever had an EKG? ☐ Yes ☐ No If yes, when? _______________________________

What was the EKG result? ☐ Normal ☐ Abnormal ☐ Unknown

For women only:

Date of last menstrual period: ____________ Are you currently pregnant or do you think you might be pregnant? ☐ Yes ☐ No

Are you planning to get pregnant in the near future? ☐ Yes ☐ No Birth control method: __________________________

How many times have you been pregnant? ________ How many live births? ________

Your Past Psychiatric History:

Please list your current or previous mental health providers (such as psychiatrist, therapist):

Name	Specialty (for example: psychiatrist, therapist)	Dates of treatment

Please list any previous outpatient programs (such as intensive outpatient program, partial hospital program):

Name	Type of program / Reason for admission	Dates of treatment

Please list any previous psychiatric hospitalizations:

Hospital Name	Reason for admission	Dates hospitalization

Please list any previous psychiatric medications you have been on:

Name of medication	Dosage	Dates taken?	Response / Side-Effects

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for any of the following?

Issue	Yes or No	If yes, which Family Member
Depression	☐ Yes ☐ No	______________________
Anxiety	☐ Yes ☐ No	______________________
Bipolar Disorder	☐ Yes ☐ No	______________________
Schizophrenia	☐ Yes ☐ No	______________________
Suicide / Suicide Attempt	☐ Yes ☐ No	______________________
PTSD	☐ Yes ☐ No	______________________
Alcohol Abuse	☐ Yes ☐ No	______________________
Other Substance Abuse	☐ Yes ☐ No	______________________
Violence	☐ Yes ☐ No	______________________
Other: ______________	☐ Yes ☐ No	______________________

Your Substance Use History:

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If yes, for which substances? ______________________________________

Where were you treated and when? ______________________________________

How much alcohol do you usually consume? ______________________________________

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Do you think you may have a problem with alcohol or drug use? ☐ Yes ☐ No

Have you ever tried any of the following substances?

Substance	Yes	No	If yes, how long and when did you last use?
Methamphetamine	☐	☐	______________________________
Cocaine	☐	☐	______________________________
Stimulants	☐	☐	______________________________
Heroin	☐	☐	______________________________
LSD or Hallucinogens	☐	☐	______________________________
Marijuana	☐	☐	______________________________
Pain Killers	☐	☐	______________________________
Methadone	☐	☐	______________________________
Tranquilizers / Sleeping Pills	☐	☐	______________________________
Alcohol	☐	☐	______________________________
Ecstasy	☐	☐	______________________________
Other:____________________	☐	☐	______________________________
Other:____________________	☐	☐	______________________________
Other:____________________	☐	☐	______________________________

Your Tobacco History:

Do you currently smoke cigarettes? ☐ Yes ☐ No

How many packs per day on average? ___________

And for how many years? _________

Have you smoked cigarettes in the past? ☐Yes ☐ No

How many years did you smoke? ________

When did you quit? ________________________

Your Family Background and Childhood History:

Were you adopted? ☐ Yes ☐ No

Where were you born? ____

Where did you grow up? ____

List your siblings and their ages:

______________________ __________ ______________________ __________

______________________ __________ ______________________ __________

What is/was your father's occupation? ____________________________________

What is/was your mother's occupation? ____________________________________

Your Educational History:

Highest educational level/degree attained? _________________ What did you study? ____________________________

Which school? ________________________________ When did you graduate? __________________________

Your Occupational History:

Are you currently: ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired

How long have you been in your present position? ______________________________

What is/was your occupation? ______________________________

Where do you work? ______________________________

Have you served in the military? _______

Your Relationship History and Current Family:

Are you currently: ☐ Married ☐ Divorced ☐ Partnered ☐ Single ☐ Widowed

If you are in a relationship, for how long have you been in it? ______________________

Do you have children? ☐ Yes ☐ No If yes, list ages and gender:

____

____

Who do you live with currently?

____

____

Legal:

Have you ever been arrested? _______ Do you have any pending legal problems? _______________

Trauma:

Have you ever been the victim of any violence or trauma? ___________

Is there anything else that you would like Dr. Lee to know?

____

____

____

____

Emergency Contact:

Name: ______________________________ Relationship to You: ______________________________

Emergency Contact's Tel Number: ____________________ Email Address: ______________________________

Preferred Pharmacy:

Name: ______________________________ Address: ______________________________

Tel Number: ______________________________ Fax Number: ______________________________

Insurance Information:

Policy Holder's Name: _________________________________ Policy Holder's Birthdate: _____________________________________

Relationship to patient: _________________________________ Policy Holder's Tel: ____

Insurance Company: ____

ID Number: ____ Group Number: ____

Member Service's Tel Number on the Back of Card: ____

Please acknowledge that you have read and understood the Privacy Practices of the office of Norman Lee, MD.

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third-party payers.
• Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand the Notice of Privacy Practices has been made available to me. It describes how medical information about me may be used and disclosed, and how I can access this information. I understand that Norman Lee M.D. has the right to change its Notice of Privacy Practices from time to time and that I may request updates to obtain a current copy of the Notice of Private Practices.

Patient Name: ____

Signature: ____

Date: ____

NORMAN LEE M.D. LLC

Email: NormanLeeMD@NormanLeeMD.com
Tel: 646-535-8826
Fax: 646-219-0961

Financial Agreement

Patient Name: ____ **Birthdate:** ________________

I authorize Dr. Norman Lee to charge the credit card provided below for appointments, sessions, and services. This card will be charged after the services are rendered unless alternate arrangements are made in advance of the appointments, sessions, or services.

I also authorize Dr. Lee to charge the card in the event there is a failure to show for a scheduled appointment or the appointment is not cancelled at least 48 hours in advance. Furthermore, for outstanding payments of services rendered, I authorize Dr. Lee to charge the credit card for the full amount due. I will not dispute charges for sessions that have been received or have been cancelled less than 48 hours in advance.

If I dispute a charge, I authorize Dr. Lee to disclose information about the appointment attendance/cancellation to the credit card company. Additionally, if payment is not made, the attendance/cancellation information may be disclosed for the purpose of collecting the said fee.

Cardholder Name: ____

Card Type (please check): ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS

Number: ____ Expiration date: ________________

CID (3-digit code on back of card) (4-digit code on front of card for AmEx): __________________________________

Billing Address: ____

____ ______________________________________

Signature **Date**

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Patient Request for Communications via Email, Text, or Telephone

Patient Name: ____ Birthdate: _______________________________

E-mail Address: ____ Telephone: ______________________________

I request to communicate with my provider via unencrypted email, telephone, or text.

I understand and agree to the following:

- The email address and telephone number I provided are accurate and that I accept full responsibility for messages sent to or from this address/number.
- I understand and acknowledge that communications over the internet or using unencrypted email may not be secure and there is no assurance of confidentiality of information communicated.
- I agree to hold Norman Lee M.D. LLC and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate in this manner.

____ ______________________________________

Signature of patient **Date**

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Request / Authorization to Release Confidential Records and Information

Patient Name: ____ Date of Birth: ____________________

Street Address: ____ Phone: __________________________

City: ___________________________________ State: ____________ Zip Code: ________________________

I hereby authorize the release of my protected health information to and from the following doctors/entities:

1. Norman Lee, MD
   Email: NormanLeeMD@NormanLeeMD.com
   Tel: 646-535-8826
   Fax: 646-219-0961

2. Person or facility: ____
   Address: ____
   Tel: ____ Fax: ____
   Email: ____

3. Person or facility: ____
   Address: ____
   Tel: ____ Fax: ____
   Email: ____

4. Person or facility: ____
   Address: ____
   Tel: ____ Fax: ____
   Email: ____

The purpose for this request to release medical information is:

□ Medical Care / Treatment

□ Other __________________________________

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken.

____ ____

Patient Signature **Date**

NORMAN LEE M.D. LLC

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OUT-OF-NETWORK BENEFITS

Dr. Lee does not participate in any insurance plans. He is considered an out-of-network provider. Payment is due at the time of services unless other arrangements are made with the doctor. Many health insurance plans offer substantial out-of-network benefits which will reimburse a generous portion of your treatment costs. Dr. Lee will provide you with a monthly invoice/superbill with the necessary information so that you may submit a claim to your insurance company.

Please use the following worksheet to learn more about your individual insurance plan's benefits as you assess your out-of-pocket expenses. Call the number on the back of your insurance card and ask your representative the questions below.

- Note the date and time of the call. Ask the representative for his/her name and direct contact number.
- "Does my insurance plan include out of network benefits for outpatient behavioral/mental health? If so, what are the benefits?"
- "Do I need to obtain prior authorization to have these services covered?"
  The most common services that the doctor providers include:
  90792 - Initial Diagnostic Evaluation
  99213 - Follow-Up Evaluation and Management Appointment
  90833 or 90866 – Psychotherapy
- "Does my plan have a deductible that I am expected to meet before my benefits kick in? If so, what is the amount?"
- "When my benefits do kick in, how much will be covered and how much will I be responsible for?" For example, a plan might have a deductible of $1000. After you have spent this much, your plan will reimburse 70% of the bill.
- "Does my plan have an out of pocket maximum after which, the entire bill will be covered?" For example, a plan might reimburse 70% of your bill, but after your total cumulative spending has reached $2500, your insurance company will cover the entire bill.
- "Are there specific claim forms that I must submit and is there a time frame in which the claims must be sent in? Where do I submit the claims?"