Welcome to the Integrative and Wholistic Psychiatric Practice of Dr. Dana Shaw:

Confidentiality:

In general, your documented agreement is necessary to provide any information to others, including family members. Exceptions required by law are threats of serious danger to yourself or others, a court order, or suspected abuse.

Scheduling Appointments:

Please e-mail *Dr. Shaw* with appointment requests at danashawmd@gmail.com.

Cancellations and Missed Appointments:

Cancellations made in less than 2 business days, as well as missed appointments, will be charged in full, except in the case of true emergencies. Monday appointments must be cancelled by the preceding Thursday, etc. This is to allow time to fill the appointment. Fees are due at the following appointment. For cancellations, please e-mail *Dr. Shaw*.

Payment Policies:

Payment is due at the time of service. Cash and credit cards are accepted.

Fees:

Evaluation 45-60 min: $350-400
Follow-up 45 min: $300
Follow-up 20-30 min: $200-$250

Receipts can be provided for Insurance purposes. Brief and emergent phone calls and emails will not incur a charge. It is requested that a credit card be kept securely on file for copay and missed appointment charges.

Contact Information:

Please contact *Dr. Shaw* at danashawmd@gmail.com. *Dr. Shaw* will make every attempt to respond within 1 business day, excluding weekends and holidays. Her emergency phone number for established patients with an urgent medical need is: 347-552-1300. If Dr. Shaw is out of the office, covering physician information will be provided on her emergency line and e-mail response.

Medication Refills:

Please have your pharmacy send refill requests via e-prescription or secondarily via fax to: 1-646-219-8140 and allow 24-48 hours, not including weekends or holidays. Please plan ahead with this is mind.

Forms:

Please print and fill out all forms and bring them to your first appointment.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE.

_____ _____ _____

(Printed name) (Signature) (Date)

REGISTRATION

NAME: Last _____ First _____ MI _____

ADDRESS: Street _____ Apt# _____

City_____ State _____ Zip _____ SEX: M F DOB: _____/_____/_____

PHONE: H: _____ W: _____ C: _____ Preferred: H W C (circle)

E-MAIL: _____ SOCIAL SECURITY #: _____

OCCUPATION: _____ Disabled Retired Student

EMPLOYER NAME: _____ Address: Street _____

City _____ State _____ Zip _____

EMERGENCY CONTACT: Name _____ Phone: _____

Relationship _____

BILLING:

PLEASE FILL OUT IF GUARANTOR IS OTHER THAN THE REGISTRANT

Name_____ Street Address: _____

City_____ State _____ Zip_____ Phone: _____

INSURANCE: Company: _____ ID#: _____

Group #: _____ Policy Holder: _____

Phone: _____

I authorize the release of any information necessary to process my insurance claims, and agree to pay all charges not covered by my insurance.

By signing below, I consent to evaluation and treatment recommendations by *Dr. Dana Shaw.*

_____ _____

(Printed Name) (Signature)

HIPAA Authorization

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights to privacy regarding my protected health information (PHI). By signing this authorization, I permit *Dr. Dana Shaw* to use and/or disclose individually identifiable health information (PHI) about my medical history, lab results and outcomes of any therapies provided only under the following conditions:

* with my documented permission or at my request
* the purpose(s) is/are provided so that I can make an informed decision whether to allow the release of the information
* *Dr Shaw* will not receive payment or other remuneration from a third partly in exchange for using or disclosing information with our my consent or participation

MESSAGES:

I give Dr. Shaw permission to leave a medical message on my (number in order of preference):

____ Home voice mail Phone: _____

____ Work voice mail Phone: _____

____ Cell phone voice mail Phone: _____

____ E-mail Address: _____

If I cannot be reached directly or by the above means, *Dr. Shaw* may leave a message with:

_____ _____ _____
(Name) (Relationship) (Phone)

I HAVE READ, UNDERSTAND, AND AGREE WITH THE ABOVE.

_____ _____ _____
(Printed name) (Signature) (Date)