

Daniel S Mundy MD

26 Court St. Suite 2218
Brooklyn, NY 11201
Phone: (646) 801-1246 Fax: (646) 863-4471
<http://danielmundymd.com>

Patient Information Form

Please provide the following information and bring this form to your first appointment

Patient Name: _____

DOB: _____

Address: _____

N# (if CHP): _____

(Please circle the best number at which to call you)

Mobile Phone: _____

Home Phone: _____

Work Phone: _____

E-mail: _____

Social Security Number: _____

Emergency Contact Name: _____

Relation: _____

Phone: _____

Primary Care Physician (if applicable): _____

Phone: _____

Address: _____

Therapist or referring psychiatrist (if applicable): _____

Office Phone: _____

Address: _____

If you anticipate that you may want Dr. Mundy to contact any of the above-named parties, you may want to complete a Release of Information (available at <http://danielmundymd.com/policies-and-forms.html>).

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Date: _____

I, _____, authorize the individuals and/or institutions named below to release any and all information related to my treatment and medical/ social/ psychiatric history to Dr. Daniel Mundy.

I authorize Dr. Mundy to discuss my treatment with the parties named below for the purpose of facilitating my treatment. I understand that Dr. Mundy will only discuss details of my treatment necessary to my care.

(Please list the parties covered by this release)

Name	Phone	Fax
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I may revoke this authorization by delivering written, signed notice to Dr. Mundy by hand or by certified mail.

Signature of Patient

Printed Name

Date

Signature of Consenting Party
(If patient is under 18 years old)

Printed Name

Date

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Practice Policies

Initial consultation:

It is common for individuals to consult more than one psychiatrist prior to engaging in treatment. The first office visit is a consultation visit. During the consultation, I will obtain background information including the individual's previous psychiatric treatment, medical treatment, and relevant family and social history. This is an opportunity for the individual to help me understand what they are seeking from a mental health professional. Perhaps most importantly, it is a time for us to decide what treatment approach will be the most helpful, whether or not I am a good "fit" for them, and whether or not to proceed with treatment. In the event we are unable to proceed with treatment, I will help to provide referrals to the most appropriate provider. A consultation is not a guarantee that I will be able to take the individual on as a patient.

Confidentiality:

Law protects the confidentiality of all communications between a patient and their psychiatrist. I will not reveal that you are in treatment with me, or the contents of this treatment, without your written permission. You may revoke this permission in writing at any time. The legal exceptions to this confidentiality include, but are not limited to, the following:

1. There is good reason to believe you are threatening serious bodily harm to yourself or others. The psychiatrist may be required to take protective actions, which may include notifying the police or any potential victims, contacting your emergency contact, or arranging appropriate hospitalization to ensure safety.
2. There is good reason to suspect abuse and/or neglect towards children, the elderly, or disabled persons. Physicians are required by New York State law to file report with the appropriate state agency.
3. A court order may subpoena a medical record.
4. In the case of a medical emergency, a treating psychiatrist may provide necessary information to the treating medical party.
5. In rare situations, a physician may utilize a court or collection agency to make a claim on a delinquent account. This is an exceedingly rare situation, and it would not occur without many previous attempts to discuss the issue with the patient.
6. To maximize the care of a patient, a physician may professionally consult with a colleague. The patient's name and unique identifying characteristics will not be disclosed in these circumstances. The consultant is also legally bound to keep any information disclosed confidential.

"Split treatment" or "collaborative treatment":

I am quite comfortable prescribing medication to a patient who is engaged in therapy with a non-psychiatrist (e.g. a clinical psychologist or a clinical social worker). In order to provide the most optimal care, I require a telephone referral from the treating therapist. I also require the patient to sign releases of information such that their therapist and I can communicate about the patient's care. I expect the patient's therapist to be accessible to me by telephone after the initial consultation and at least monthly once I begin treatment with their client. I expect the patient's therapist to relate to me any relevant clinical information that may reasonably guide pharmacologic management or emergency treatment (e.g. worsening, improvement, or development of new symptoms). In rare situations where the therapist is unwilling or unable to perform the above duties, I cannot, in good conscience, continue providing treatment to the patient. I will arrange appropriate referrals, if warranted, for continuation of medication management.

Cancellation policy:

I require notice of cancellation at least 72 hours prior to the scheduled appointment. For example, to cancel a 6 PM appointment on a Monday, I require notification of cancellation by 6 PM the previous Friday. Upon learning of a cancellation, I will make every effort to fill the time with another established patient. If I am unable to fill the time slot and notification has been less than 72 hours, the patient will be charged for the scheduled visit.

Billing policy:

Patients with whom I meet weekly will be billed on a monthly basis with payment due on receipt of the bill. I accept checks, most major credit cards, and cash. Accounts overdue for more than 30 days will be charged a late fee of 5% of the total balance overdue. In rare circumstances, sessions may be temporarily stopped (except in emergency) until payment is received. Accounts overdue by more than 90 days may be turned over to a collection agency.

For patients whom I meet with less than weekly, and for initial consultations, payment is expected at the time of service in full. If payment is to be mailed after the appointment, the account will be subject to the policies described above.

I understand situations may arise that could delay payment, and I am willing to work with the patient in specific situations.

Insurance:

At present, I do not participate on any insurance panels other than Consolidated Health Plan - NYU. Many health insurance companies and professional benefit plans allow submission of a psychiatrist's bill in return for substantial reimbursements. I encourage patients to contact their insurance carrier, prior to their first visit, and to ask about their out-of-network mental health deductible and reimbursement. This information is necessary prior to discussing "sliding scale" charges for office visits.

Medication refill policy:

Medication refills should be handled during scheduled appointments. If the patient discovers they will run out of medications prior to their scheduled appointment, they should contact me to call in a refill. In New York State, controlled substances require the original written prescription, though some pharmacies will dispense a brief supply on receipt of a fax copy of a new prescription.

For patients whom are seen predominantly for medication management, it is important to have an appointment in order to renew medication. It is common practice for a psychiatrist to phone in a small supply of medication that will last until the next scheduled visit. I do this to ensure proper evaluation of symptoms and medication response.

Controlled substance policy:

Controlled substances require more responsibility from both the patient and the prescriber. New York State encourages physicians to monitor all controlled substances a patient is prescribed through an electronic registry. If a patient repeatedly loses prescriptions or requests early refills, we must have a conversation about the appropriateness of continuing the medication. Similarly, if a patient obtains a psychiatric controlled substance from another prescriber without alerting me, we may need to discuss the appropriateness of continuing a controlled medication.

Sarah Schur McCarty, M.D.:

I share office space with a colleague, Dr. Sarah Schur McCarty. We are independent solo-practitioners, as such, we do not share responsibilities for each other's patients unless specified.

AUTHORIZING SIGNATURE (S)

PATIENT or CONSENTING PARTY

I have read, understand, and agree with Dr. Daniel Mundy's Practice Policies, and I have been provided a copy. My signature below indicates that I agree to abide by these policies.

Signature of Patient

Printed Name

Date

Signature of Consenting Party
(If patient is under 18 years old)

Printed Name

Date

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Practice Policies- NYU CHP Addendum

Cancellation policy:

I require notice of cancellation at least 72 hours prior to the scheduled appointment. For example, to cancel a 6 PM appointment on a Monday, I require notification of cancellation by 6 PM the previous Friday. Upon learning of a cancellation, I will make every effort to fill the time with another established patient. If I am unable to fill the time slot and notification has been less than 72 hours, the patient will be charged a \$50 fee. While this may seem punitive, please keep in mind that CHP, who pays for office visits, does not pay for services not rendered. As such, I lose a significant amount of business when insured patients cancel and their time-slots cannot be filled..

Claim submission and payment:

I submit claims to CHP, who in turn pays me for services provided. As different levels of psychiatric intervention warrant different insurance reimbursements, I am frequently unable to estimate how much a patient will ultimately owe me in co-insurance (i.e. "What is their copay") per visit. This is generally clarified after the first three visits. Typically, I wait until CHP reimburses me for follow-up visits prior to billing a patient. I am willing to discuss standing payments if a patient is concerned about receiving one larger payment.

Like any doctor on an insurance panel, I submit information on a patient's diagnosis, treatment, and, when absolutely necessary, personal medical records to CHP. It is important for the patient to understand this information is only submitted to provide insurance coverage for services rendered. The patient's signature below acknowledges that their medical information will be released to Consolidated Health Plan for purposes of treatment and reimbursement.

AUTHORIZING SIGNATURE(S)

PATIENT or CONSENTING PARTY

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Printed Name

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Credit/ Debit Card Authorization

CREDIT/ DEBIT CARD TYPE (circle): VISA MASTERCARD AMERICAN EXPRESS

NAME ON CARD: _____

CREDIT/ DEBIT CARD NUMBER: _____

EXPIRATION DATE: MONTH: _____ YEAR: _____

BILLING ZIP CODE: _____

CVV#: _____

AUTHORIZING SIGNATURE (S)

PATIENT or CONSENTING PARTY

My signature below indicates that I agree to allow Dr. Daniel Mundy to charge the above debit/credit card for services provided.

Signature of Patient

Printed Name

Date

Signature of Consenting Party
(If patient is under 18 years old)

Printed Name

Date