New Patient Form (TOCDOC)

New patient intake form

* Required

1. **Email address** *

2. **Patient's full name** *

3. **Patient's age (in years)** *

4. **Patient's date of birth** *

   Example: December 15, 2012

5. **Patient's sex** *

   Mark only one oval.

   - ◯ Female
   - ◯ Male
   - ◯ Prefer not to say

6. **Patient's phone number** *

7. **Patient's mailing address, City, State, Zipcode** *

8. **Patient's insurance (Payer name)** *

   Mark only one oval.

   - ◯ BlueCross BlueShield of Illinois
   - ◯ Other:

9. **Patient's insurance (Plan name and type)** *
Mark only one oval.

- Blue Choice PPO
- Other: _____

10. **Who is the primary member of patient's insurance plan (name and address)** *

_____

11. **Patient's insurance (Member ID)** *

_____

12. **Patient's insurance (Group ID)** *

_____

13. **Patient's insurance (Relationship to Insured)** *
Mark only one oval.

- Self
- Spouse
- Child
- Other: _____

14. **Patient's emergency contact (name, phone number, relationship)** *

_____

15. **Patient's marital status** *
Mark only one oval.

- Married
- Single
- Divorced
- Separated
- Significant other
- Other: _____

16. **Employment status** *
Mark only one oval.

- Full time
- Part time
- Unemployed
- Retired
- Disabled
- Other: _____

17. **Highest level of education** *

18. **Have you served in the military** *

Mark only one oval.

- Yes
- No
- Other:

19. **Primary care physician (name, phone number, fax)** *

20. **Current therapist (name, phone number, fax)** *

21. **What is the patient seeking our help for?** *

22. **What are the patient's current medications? (names, dosage, reason it was prescribed)** *

23. **What allergies does the patient have? (name the allergen and the reaction)** *

24. **Current mental health diagnosis** *

25. **Current mental health treatment** *

26. **Have you ever been in a psychiatric hospital? When and what led to the hospitalization (s)?** *

27. **Have you ever attempted suicide? What method did you use?** *

28. **How you ever harmed someone else? What was the consequence of your behavior?** *

29. **Current medical conditions** *

30. **Previous surgeries** *

31. **Smoking status** *
Mark only one oval.

- ◯ Never smoked
- ◯ Former smoker, not smoking anymore
- ◯ Active smoker
- ◯ Other

32. **How many caffeinated beverages do you drink per day?** *
Mark only one oval.

- ◯ 2 or less
- ◯ More than 2

33. **Are you currently using any of these?** *
Check all that apply.

- ☐ Alcohol
- ☐ Marijuana
- ☐ Hallucinogens (LSD)
- ☐ Heroin
- ☐ Methamphetamine
- ☐ Cocaine
- ☐ Stimulants
- ☐ Ecstasy
- ☐ Methadone
- ☐ Tranquilizers
- ☐ Pain killers
- ☐ Bath salts
- ☐ Incense/Potpourri
- ☐ None
- ☐ Other:

34. **Do you have any active legal issues?** *
Mark only one oval.

- ◯ No
- ◯ Yes
- ◯ Other: _____

35. **Does anyone else in your family have mental illness? If so, who and what is there diagnosis?** *

_____

36. **Has anyone in your immediate family attempted suicide? Who and what was the consequence?** *

_____

37. **Is there anything else in particular that you want the doctor to know about you?** *

_____

_____

_____

_____

_____

38. **How did you find us?** *
Mark only one oval.

- ◯ Online search
- ◯ Referral by a healthcare provider
- ◯ Word of mouth
- ◯ Other: _____

39. **Date this form was filled** *

_____
Example: December 15, 2012

☐ Send me a copy of my responses.

Patient Forms

TOCDOC, 411 Clarendon Court, Suite 104, Savoy, IL 61874, Phone: 815-6836109, Email: drbhosale@tocdoc.life

* Required

1. **Email address** *

Patient HIPAA Acknowledgement Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.
To comply with one of HIPAA’s requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

2. **Do you acknowledge?** *
   Check all that apply.

   ☐ By checking this box, I acknowledge that I have today received a copy of the Notice of Privacy Practices.

PATIENT CONSENT FOR TREATMENT

I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: (1) the scope of the provider’s license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.
If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.
By signing below, you certify that you have been informed and understand the terms stated in the Treatment Consent Form. You indicate that you understand the scope of my services, session structure, fees, cancellation/no-show policies, payment policy, insurance reimbursement, confidentiality, sharing of information, the nature of my practice, and my contact information, and that you agree to abide by the terms stated above during the course of our therapeutic relationship.
I understand that I have the right to receive a copy of this consent and right to withdraw this consent at any time via a written request.

3. **Do you agree and consent?** *
   Check all that apply.

   ☐ By checking this box, I agree and consent to participate in mental health care services offered and provided at/by NITIN BHOSALE, MD, a behavioral health care provider.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for The Oval Circle, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).
(The Notice of Privacy Practices provided by The Oval Circle, LLC describes such uses and disclosures more completely.)
I have the right to review the Notice of Privacy Practices prior to signing this consent.
The Oval Circle, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Nitin Bhosale, 411 Clarendon Court, Suite 104, Savoy, IL 61874
With this consent, The Oval Circle, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
With this consent, The Oval Circle, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”
With this consent, The Oval Circle, LLC] may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that The Oval Circle, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The Oval Circle, LLC may decline to provide treatment to me.

4. **Do you consent?** *
   Check all that apply.

   ☐ By checking this box, I am consenting to allow The Oval Circle, LLC to use and disclose my PHI to carry out TPO.

Patient Financial Responsibility

I understand I am responsible for fees incurred at the time of service at TOCDOC (The Oval Circle, LLC). For your convenience, we offer several payment options, including point-of-sale (POS) and online payment services. We take personal checks as well as all major credit cards. We will provide you with an invoice, at your request.
If I fail to pay any outstanding fees or charges, I understand that my balance may be turned over to a collection agency and/or my debt may be reported to the credit bureau if the bill is not paid within 90 days of last date of service.

Cancellation / No Show Policy:

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. I understand that if I cancel within less than 24 hours of notice of my appointment time or I do not show up, TOCDCOC (The Oval Circle, LLC) has the right to issue a cancellation fee up to the full cost of the scheduled appointment.
I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.
The Practice will notify you in writing, via certified mail, if you are discharged from care.

5. **Do you agree?** *
   Check all that apply.

   ☐ By checking this box, I confirm that I have read and understand the above information, and I agree to the terms described.

6. **Patient name** * (Please sign next to your name)
   Please sign next to your name

7. **Date** *

   Example: December 15, 2012

Release of Information Form

I hereby authorize Nitin Bhosale, MD to share information with the entity/entities mentioned below.
I may cancel this authorization by checking “CANCEL” on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.
Please be advised that certain information could be shared without patient's authorization in emergency situations to maintain safety of patient and others.

* Required

1. **Email address** *

2. **What is the purpose of this form?** *
   Check all that apply.

   ☐ By clicking this checkbox, I hereby authorize Nitin Bhosale, MD to share information with the entities mentioned below

   ☐ By clicking this checkbox, I CANCEL any prior authorization given to Nitin Bhosale, MD to share information with the entities mentioned below

3. **Name, Telephone, Fax and Address of the person/entity with whom your information will be shared**

4. **What information can be shared?** *
   Mark only one oval.

   ◯ Mental health record (includes substance use information recorded as part of mental health evaluation and treatment)

   ◯ Other:

5. **Patient name** * (Please sign next to your name)

6. **Date of birth** *

   Example: December 15, 2012

7. **Today's date** *

   Example: December 15, 2012

Telemedicine Consent Form

TOCDOC, 411 Clarendon Court, Suite 104, Savoy, IL 61874, Phone: 815-6836109, Email: drbhosale@tocdoc.life

* Required

1. **Email address** *

2. **I understand that my health care provider wishes me to engage in a telemedicine consultation. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.** *

   Check all that apply.

   ☐ By clicking this checkbox, I certify that I have read this form, that I fully understand its contents including risks and benefits and I consent to engage in a Telemedicine visit

3. **Patient name** * (Please sign next to your name)

4. **Date** *

   Example: December 15, 2012

Email/Text messaging consent form

TOCDOC, 411 Clarendon Court, Suite 104, Savoy, IL 61874, Phone: 815-6836109, Email: drbhosale@tocdoc.life

Date of consent:_____

My email address:_____

My phone number:_____

Email and Text Messaging Consent

I hereby state my preference to have my physician, Dr. Nitin Bhosale, and other staff at TOCDOC communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party. I understand that TOCDOC provides me access to a HIPAA compliant patient portal that can be used for secure messaging with the practice. I also understand that I can withdraw this consent at any time by resubmitting this form to TOCDOC (selecting "No" as an option)

1. **I consent to email/text messaging communication with TOCDOC** *
   Mark only one oval.
   - ◯ Yes
   - ◯ No

2. **Name (First, Last)** Please sign next to your name

   _____

3. **Date of Birth**

   _____
   Example: December 15, 2012