Shannon Gulliver Caspersen, MD
983 Park Avenue
New York, NY 10028
Phone: 212 774 1820
Email: contact@shannoncaspersenmd.com

Patient Information

Name:_____

Date of Birth:_____

Email Address:_____

Home Address: _____

Phone Numbers: _____

Emergency Contact Name/relationship/phone number:

_____

Allergies: _____

Non-psychiatric Medical issues: _____
Current Medications and doses: _____
Pharmacy Name, Zip Code, Phone Number:_____

Primary Care Provider Contact Information:

_____
_____
_____

Therapist or other mental health provider:

_____
_____
_____

School contact information (if applicable):

_____
_____
_____

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Authorization for Release of Information

Patient's Name_____

I hereby authorize Dr. Shannon Caspersen to contact and obtain and/or provide my medical history and other related information to/from the following individuals/institutions for the purpose of medical care, which can include information such as labwork, psychological testing, medical and psychiatric history, treatment history, and written medical records:

Name:

_____

_____

_____

Telephone:

_____

_____

_____

I understand that this correspondence may involve a conversation or a transfer of written material and that I have the right to revoke the above authorization at any time.

Signature:_____

Printed Name:_____

Date:_____

Notice of Confidentiality

It is understood and agreed to by the recipient of the document or communications requested above that this is privileged information within the doctor-patient relationship, and is confidential material by law. Further disclosure or release of the documents or their contents by the recipient of any other party is not authorized without the above patient's written consent. Furthermore, it is understood that the patient may withdraw his/her consent to this release at any time.

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Practice Policies

Scheduling Appointments:
To schedule an initial evaluation appointment, please call 212 774 1820 and leave your name, call back number, and the reason for your call. Dr. Caspersen will contact you to perform a brief phone interview in advance of the initial appointment to discuss medical/psychiatric history as well as fees. Initial evaluations typically require at least two (and sometimes three) full sessions to complete an assessment and to formulate treatment recommendations. You will be asked to fill out and sign routine forms to bring to your initial evaluation. At the end of the initial evaluation (2-3 sessions), Dr. Caspersen will provide recommendations for ongoing treatment with her, or referrals to a higher or more specialized level of care.

Cancellation:
Appointments must be canceled or rescheduled two business days in advance of the scheduled time. Appointments that are not canceled according to this time frame will be billed. The logic behind the 2-day cancellation policy of many psychiatrists is as follows: while physicians in other specialities (ophthalmology, dermatology) can double- and triple-book patients each hour, such that even if one does not come the physician is still earning money for his time, psychiatrists can only book one patient per hour, and therefore cannot earn money if there is not such a policy in place.

Duration:
Appointments are typically 45 minutes in length. Please make every effort to arrive on time, as each session must end on time out of consideration for the patient with the next appointment.

Fees and Payment Methods:

A credit card must be kept on file ,which will be billed in the case of missed appointments and those cancelled less than two business days prior to the scheduled time. Payment is due at the time of service either by check or credit card. For established patients, billing may occur on a monthly basis.

Health Insurance:
Like most psychiatrists in New York City, Dr. Caspersen is an out-of-network provider, meaning that she does not accept payments from insurance companies. If you are interested in seeking reimbursement from your insurance company, contact it directly to obtain information about your “out-of-network behavioral health coverage”. You will want to confirm: 1) if you have a deductible; 2) what percentage of fees are covered (e.g. 70 % of a total number of visits per year); 3) in what time period claims must be filed (this can vary from a couple of months to over a year from the date of service); and 4) what your company considers “reasonable and customary” for zip code 10028, which means the rate at which they will reimburse you for treatment. Some companies may request a procedure code in addition to a zip code to determine their reimbursement rate. Dr. Caspersen is always happy to provide this information and to do her best to assist in these matters.

Dr. Caspersen will provide invoices for rendered services. These invoices will include diagnosis codes and description of services (CPT codes) rendered. (Insurance companies generally require documentation with this information for out-of-network claims.) You can attach these invoices to your insurance claim forms to submit to your insurance company.

Medications:
In order for psychotropic medication to be prescribed safely and effectively, regular monitoring for side-effects/adverse reactions is necessary. Depending on the medication, this can include monitoring vital signs and weight as well as blood work in conjunction with a clinical assessment. While medication is being increased or decreased, appointments may need to be scheduled at more frequent intervals. In cases where patients are stable on a dose of medication for a long period of time, less frequent appointments may suffice. **For your safety, the minimum frequency of appointments with Dr. Caspersen is every three months.** If you run out of medication, Dr. Caspersen will provide a prescription for a few days worth of medication until you can be seen for an appointment.

When calling or emailing to request a refill, please provide in your message your name, DOB, medication name, dose, and frequency, and the name, telephone number **and zip code** of your pharmacy.

Privacy:
NOTICE OF PRIVACY PRACTICES

Information about patients remains confidential whenever possible.

Dr. Caspersen will request either written or verbal consent for **Authorization for Release of Information** from the patient for any disclosure of patient information.

Dr. Caspersen will request permission to remain in contact with the primary care physician or other key healthcare providers, to better coordinate the patient's care. Patients may wish to grant Dr. Caspersen permission to speak with family members, significant others, or teachers about their diagnoses and treatment. It will be the patient's (or parents', for those under 18) decision whether to permit this contact or not. There are rare instances when the law may require a health professional to release information about a patient without the patient's authorization, such as:

- If the physician has reason to believe that the patient poses a direct threat of imminent harm to self or others
- If the physician has reason to believe that abuse or neglect of a child, elder, dependent, or disabled person is taking place
- If the physician is ordered by a court to use or disclose information in the course of a judicial or legal proceeding.

Patients have the right to file complaints if they believe their privacy rights have been violated, both to the covered entity and to Health and Human Services. See http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html for guidelines.

I have read and agree to the Notice of Privacy Practices detailed above:

Signature: _____ Date: _____

Printed name: _____ Date of birth:_____

Relationship to patient (self, parent, legal guardian): _____

Phone, E-mail, Text Messages:

Phone is the preferred means of contacting Dr. Caspersen both for your privacy and your best clinical care. However, if you would like to communicate by email for routine administrative matters such as scheduling, billing, and medication refill messages, you may sign the email consent agreement below. Remember that email and text are not encrypted, and anything you write in them could be compromised. Therefore, Dr. Caspersen requests that clinical information or content you wish to keep private be communicated in person or live on the phone.

If you consent to use email, invoices will be emailed to you using an unencrypted billing service.

Phone conversations and email exchanges >10 minutes in length will be billed at Dr. Caspersen's hourly rate, including calls with family members, significant others, teachers, and clinicians with whom you have asked Dr. Caspersen to communicate. Unfortunately, many insurance companies do not reimburse patients for phone sessions or email exchanges.

Dr. Caspersen **DOES NOT** use text messages in her practice.

EMAIL CONSENT

I, _____(patient name)

[] authorize communication via email with my psychiatrist Dr. Shannon Caspersen.

[] DO NOT authorize communication via email with my psychiatrist Dr. Shannon Caspersen.

I am aware that there is an inherent risk in any electronic communication with regard to privacy as information can be accessed by unauthorized users in the event of password theft, server malfunction or system hacking.

I have reviewed the above and agree to communication via email. I am aware that I may withdraw my consent at any time.

Signature:_____

Printed Name:_____

Date:_____

Emergencies:
When true emergencies occur, it is appropriate to contact Dr. Caspersen at any hour, 24/7. If you are unable to reach Dr. Caspersen immediately, please call 911 or go to the nearest psychiatric emergency room. Leave a message briefly describing the situation along with a contact number so that Dr. Caspersen can return your call as soon as possible.

Vacations:
When Dr. Caspersen is on vacation or otherwise out of phone contact, she will arrange to have another physician cover her in case of emergencies. Contact information for the covering physician will be recorded on Dr. Caspersen's voicemail while she is away.
I, _____(patient/parent name) agree to the above office policies.

Signature:_____

Printed name:_____

Date:_____

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Credit Card Authorization Form

Name of Patient:_____

The office requires that patients and families keep a credit card on file as a back-up payment method in the event of bill non payment and missed appointments that were not canceled 48 hours in advance of scheduled appointment time. If you indicated on your payment method form that you would like to pay every session by credit card, your card will be charged automatically at the time of the session.

By signing below I grant permission to Shannon Gulliver Caspersen, MD to bill my credit card as per parameters outlined above.

[] Visa []MasterCard

[] American Express []Discover

Name of Card Holder:_____

Card number:_____

Expiration date:_____

CVV number:_____

Billing Address:_____
City:_____State:_____Zip:_____

Signature:_____ Date:_____