Stanley M. Hertz, M.D.
55 Fern Drive
Roslyn, NY 11576-2201
Tel (516) 484-6366 Fax (516) 484-2864
drhertz@stanleyhertzmd.com

Dear patient or parent,

I look forward to meeting and working with you. Please note the following guidelines:

Please complete the downloaded forms and return them by fax, email or mail.

APPOINTMENT INSTRUCTIONS

To provide safe care during the current health emergency, Dr. Hertz will conduct telemedicine (video chat) sessions. ***Please do not go to the office.***

Five minutes before your appointment, enter doxy.me/stanleyhertz in your internet browser's address bar and follow the on-screen instructions. Dr. Hertz will connect with you at your scheduled time.

If you are unable to do a video chat, email the patient's full name and phone number to appts@stanleyhertzmd.com. well in advance of your appointment day. Dr. Hertz will call you at your scheduled time.

Appointment reminders are sent as a courtesy; it is *your* responsibility to note the date and time of your sessions. If you must cancel an appointment, please call (516) 484-6366, option #2, as soon as possible to avoid missed appointment or last-minute cancelation charges.

TELEPHONE CALLS

All calls are returned by the next business day. If you must speak with Dr. Hertz immediately, please call (888) 700-2419.

PRESCRIPTION RENEWALS

Required prescription renewal forms may be downloaded from this site (www.stanleyhertzmd.com) and should be submitted by fax, email or mail at least ***ten days before*** you will run out of medication.

PAYMENT

Fees or Medicare copays are due by check or money order (no credit/debit cards or electronic payments) upon receipt of your bill. Please include the patient's full name on all checks.

CONFIDENTIALITY
All information between Dr. Hertz and patient is held strictly confidential unless:
1. the patient authorizes release of information with his/her signature
2. the patient presents a physical danger to self.
3. the patient presents a danger to others.
4. Child/elder abuse/neglect are suspected.

In the latter two cases, we are required by law to inform the potential victims and legal authorities so that protective measures can be taken.

FINANCIAL TERMS
Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and your provider will be paid directly by the carriers. The patient will be responsible for any applicable deductibles and copayments. If you are not eligible at the time services are rendered, you are responsible for payment. If your insurance company becomes insolvent you are responsible for all fees. **ALL FEES ARE DUE AT THE TIME OF THE APPOINTMENT.**

CANCELLED/MISSED APPOINTMENTS
PATIENTS ARE CHARGED FOR ALL MISSED APPOINTMENTS PATIENTS ARE CHARGED FOR CANCELED APPOINTMENTS UNLESS THE OFFICE IS NOTIFIED 2 BUSINESS DAYS PRIOR TO THE APPOINTMENT TIME FOR A FOLLOW UP VISIT AND 3 BUSINESS DAYS BEFORE AN INITIAL APPOINTMENT. PRIVATE PAY PATIENTS WILL BE CHARGED THEIR FULL FEE FOR MISSED/CANCELED APPOINTMENTS. PATIENTS WHO UTILIZE INSURANCE PLANS THAT DR. HERTZ PARTICIPATES IN WILL BE CHARGED $100 FOR A SHORT MISSED/CANCELED APPOINTMENT AND $200 FOR A LONGER MISSED/CANCELED APPOINTMENT.

INSURANCE
IT IS THE PATIENT'S RESPONSIBILITY TO DERTERMINE IF THEY HAVE MENTAL HEALTH BENEFITS AND WHETHER PRECERTIFICATION IS REQUIRED. THE PATIENT MUST INFORM DR. HERTZ OF ALL CHANGES IN INSURANCE INFORMATION IMMEDIATELY.

CONSENT FOR TREATMENT
I further authorize that Dr. Hertz to carry out psychiatric examinations, treatments including the use of medications, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand d that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

RELEASE OF INFORMATION
I authorize the release of information for claims, certification/case management/quality improvement, and other purposes related to the benefits of my Health Plan. I give Dr. Hertz permission to communicate with my physician and therapist, verbally and in writing.

NOTE:
Records of patients treated in alcohol or drug treatments units are protected by federal confidentiality rules (42CFR Part 2)

I irrevocably assign all my rights and benefits under any insurance contracts for payment for services rendered to me by the above named provider. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by the above named provider to be released to the above named provider of his or her agent. I irrevocably authorize the above named provider of his or her agent to file insurance claims on my behalf for services rendered to me or my dependents. I irrevocably direct that all such payments go directly to the above named provider. I irrevocably authorize the above named provider or his or her agent to act in my behalf to report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect, it applies to all occasions of service until revoked.

I accept personal responsibility for any changes not covered by my insurance policy.

Signature: _____ Date: _____

I understand and agree to all of the above information.

_____ _____
Patient (or Parent/Guardian) name printed Witness

_____ _____
Patient (or Parent/Guardian) Signature Date

_____
Date

Stanley M. Hertz, M.D. P.C.

Patient Information

Title | First Name | Middle Initials | Last Name | Dated

Address | Town | State | ZIP+4

Male / Female | **Single / Married / Other** | **Employed / Full-time / Part-time student**

Date-of-Birth | SSN | Sex (Circle One) | Marital Status (Circle one) | Employment (Circle one)

Employer or School Name | Town | Job Title

Home Phone | Office / Extension / Whose | Mobile Phone | Emergency Number & Contact | Child's School

Pharmacy Name / Pharmacy Phone # / Pharmacy Fax #

Co-therapist Name | Co-therapist phone # | Family Doctor / Pediatrician Name / Phone

Email Address (If used Regularly) | Referring Physician or Other Source

Person Responsible For Bills (Person who is Primary on Insurance)

If Patient is Responsible for Bills there is no need to re-enter information here, otherwise complete this Section.

Title | First Name | Middle Initials | Last Name | Dated

Address | Town | State | ZIP+4

DOB | SSN | Sex | Relationship to Patient

Home Telephone | Business Telephone | Employer | Print Statement of Service

Insurance Company Name | Insurance ID #

Office use only:

Date First Seen: Diagnosis:

PATIENT HISTORY

Why did you seek this consultation? _____

I have problems in the following areas (please circle)

Marriage/Relationship/Family
Job/School Performance
Learning/Reading
Friendship/Peer Relationships
Hobbies/Interest/Play Activity
Physical Health
Activities of Daily Living
(Personal hygiene, bathing etc)
Eating Habits/Bingeing/Purging/Starving
Sleeping Habits
Anxiety Level / Nerves
Mood
Sexual Functioning/Gender Issues
Financial Situations
Ability to Concentrate/Distractibility/
Attention Span
Ability to Control his/her Temper
Strange Thoughts/Strange Experiences
Habits / Repetitive Behaviors /
Obsessions / Compulsions
Hyperactivity/Tics/
Movement Problems
Memory
Impulse Control / Stealing /
Hair Pulling / Gambling

If you circled an area please describe the difficulty.

SOCIAL HISTORY

WITH WHOM DO YOU CURRENTLY LIVE

_____ relationship to you_____

_____ relationship to you_____

_____ relationship to you_____

_____ relationship to you_____

_____ relationship to you_____

HIGHEST LEVEL OF EDUCATION COMPLETED_____

CURRENTLY A STUDENT □ YES □ NO

SCHOOL CURRENTLY ATTENDING_____

_____

CURRENTLY EMPLOYED □ FULL-TIME □ PART-TIME

NAME OF EMPLOYER_____

POSITION_____

DO YOU HAVE ANY LEGAL PROBLEMS (please describe)_____

_____

_____

_____

_____

ANY OTHER SIGNIFICANT SOCIAL ISSUES (please describe)_____

_____

_____

_____

_____

MEDICAL HISTORY

HEIGHT _____ WEIGHT _____

Date of last physical exam _____ Date of last lab test _____

Please list any prescription or over the counter medication you are taking (name, dosage, frequency)

_____

_____

Please list any past medical difficulties

_____

_____

Please list any current medical problems

_____

_____

Allergies ☐ No ☐ Yes, please list

_____

Any other Information

_____

My current physician is: _____ Address _____ Tele _____

Office use only ☐ No acute medical problems

FAMILY HISTORY: Please describe any medical or psychiatric conditions of relatives. If the relative takes or has taken a psychiatric medication (antidepressants, tranquilizers) please list

_____

_____

Office Use only ☐ No psychiatric hx

Maternal line _____

Paternal line _____

HABITS ☐ Coffee (cups/day) How much currently? _____

☐ Cigarettes (packs/day) How many currently? _____

☐ Alcohol – Please describe usage _____

☐ Drugs _____

PSYCHIATRIC HISTORY

☐ Currently in treatment with _____
Name

_____ _____
Address Telephone

I have been in treatment for _____ months/years.

I am currently working on these issues _____

_____

☐ Past psychiatric treatment

Hospitalization(s): Hospitals Year

_____ _____

_____ _____

_____ _____

_____ _____

Outpatient therapist(s): Name Year(s) Helpful? Yes/No

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication(s): Name Dose Years taken Effective? Yes/No

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Other pertinent information: _____

Dear Patient:

It is very important that I communicate with your therapist and primary care physician after your consultation. One of the difficulties I have encountered is tracking down their addresses and telephone numbers. ***Please take a few moments to complete this form prior to our initial appointment, or attach your doctor's and/or therapist's business cards.***

PRIMARY CARE PHYSICIAN/INTERNIST/PEDIATRICIAN

Doctor's name:_____

Address:_____ Suite #_____

City:_____ State:____ Zip Code:_____

Telephone:_____

THERAPIST

Name:_____M.D.__Ph.D __MSW___Other_____

Address:_____ Suite #_____

City:_____ State____ Zip Code:_____

Telephone:_____

Please check below if you **do not** want me to contact your:

Primary care physician_____ Therapist_____

Thank you.

PRESCRIPTION (RX) RENEWALS

A renewal is for the ***EXACT* RX** you previously received, with **NO** changes of any kind. If anything has changed, you must speak directly to Dr. Hertz.

The most efficient way to get a renewal is to call your pharmacy and ask them to electronically transmit the request to Dr. Hertz. Once received, allow 2 BUSINESS days for processing; then you may call the pharmacy **(*NOT Dr. Hertz*)** to find out if your RX is ready for pick-up. Please do not duplicate your request in writing or by phone. You do not have to let Dr. Hertz know that your pharmacy is requesting a renewal. If your pharmacy will not extend this courtesy to you, you may send a renewal form to the office.

RX renewal forms may be downloaded from *stanleyhertzmd.com* or picked up in the waiting room. They may be emailed to *appts@stanleyhertzmd.com*, faxed to (516) 484-2864 or mailed at least **10 days before** you will run out of medication.

All renewal requests must be legible and include:

Patient name
Date of birth
Name of medication, brand or generic
Dosage
How many times you take it per day
30, 60, or 90 day supply
Name, address and **zipcode** of pharmacy

INCOMPLETE REQUESTS WILL NOT BE PROCESSED

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PRESCRIPTION RENEWAL FORM

Please submit this form 10 days before you need a renewal. Your prescription will be renewed only if you have seen Dr. Hertz in the past 3 months. If you have not seen Dr. Hertz in the past three months, please call the office to make an appointment.

The information requested on this form may be submitted by mail, e-mail or fax.

Your prescription will be sent electronically to your pharmacy or mail order service.

INCOMPLETE REQUESTS WILL NOT BE PROCESSED

PLEASE PRINT

PATIENT NAME_____DATE OF BIRTH_____

MEDICATION NAME_____

DOSAGE _____

DIRECTIONS (HOW MANY TIMES PER DAY)_____

30 DAY SUPPLY_____60 DAY SUPPLY_____ 90 DAY SUPPLY_____

PHARMACY OR MAIL ORDER SERVICE NAME_____

PHARMACY ADDRESS_____

PHARMACY ZIPCODE_____