PATIENT ACKNOWLEDGMENT: HIPAA

PRACTICE OF DEBORA BARCHILON, M.D.

Effective Date: 12/22/20

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of

Debora Barchilon, MD.

Patient :_____

_____

Signature of Patient (or authorized representative) DATE

DEBORA BARCHILON, MD
555 EAST 87TH STREET
NEW YORK, NY 10128

PATIENT NOTIFICATION REQUIRED BY NY PUBLIC HEALTH LAW SECTION 24

HEALTHCARE PLAN PARTICIPATION STATUS:

I am not a participating physician with any healthcare plans.

AVAILABILITY OF WRITTEN STATEMENT OF FEES

If I do not participate in the network of your healthcare plan, a written statement of fees for non-emergency services is available upon request.

Because I am not a participating physician in your healthcare plan, your healthcare plan may (i) not cover out-of-network services at all, (ii) impose higher deductible and/or copayments for out-of-network services or (iii) reimburse you for a lesser amount than my fees. You are responsible for payment of the full fees regardless of what reimbursement you may or may not receive from your healthcare plan.

Read and Acknowledged by

_____ on _____

Signature of Patient or Legal Guardian

_____

Debora Barchilon, MD

55 East 87th Street
New York, NY 10128
Tel: 212 875 2025

Email: info@TheBarchilonCenter.com
Website: TheBarchilonCenter.com

Cancellation Policy

I, _____ understand that the initial consultation appointment may be cancelled without a charge if I give 3 business days' notice and at least 72 hours' notice (eg 10:30 AM Thursday for 10:30AM Tuesday), except in the event of a medical emergency. Follow up appointments may be cancelled without a charge with at least 5 business day's notice, except in the event of a medical emergency.

If I miss a scheduled appointment, or cancel in less than the required amount of time, I will be billed in full for my appointment.

I agree to be personally and fully responsible for payment and understand that charges for late cancellations are not covered by insurance.

X_____ _____

Signature Date

Debora Barchilon, MD

55 East 87th Street
New York, NY 10128
Tel: 212 875 2025

Email: info@TheBarchilonCenter.com
Website: TheBarchilonCenter.com

Correspondence Policy

Due to privacy concerns, Dr. Barchilon does not address any practice matters or clinical questions, including cancellations or appointment scheduling, by email or text messaging unless specific arrangement have been made.

If you have any questions regarding a clinical issue or need to make or change an appointment, please call the office directly at 212-875-2025.

If you need to reach the doctor after regular office hours please call the Doctor on her cell phone or the covering physician, when Dr. Barchilon is away on vacation.

In the event of a medical emergency, please leave a message on Dr. Barchilon's voicemail and call 911 or go to the nearest Emergency Room of assistance. Please have the ER attending Physician call Dr. Barchilon to co-ordinate care.

_____ _____

Print Name Date

X _____

Patient Signature

Debora Barchilon, MD

55 East 87th Street
New York, NY 10128
Tel: 212 875 2025

Email: info@TheBarchilonCenter.com
Website: TheBarchilonCenter.com

Prescription Refill Policy

Prescriptions will only be refilled if you call the office directly at 212-875-2025. If you need your prescription urgently, please follow the instructions to page Dr. Barchilon or the covering physician.

When you call, please be prepared to give the name of your medication, the pill strength, the number of times per day the medication is taken, the total daily dose, and a list of other medications being taken, as well as the name and address of the pharmacy where you need it to be filled.

Additionally, please allow two business days for refills to be completed.

Thank you for your cooperation.

_____ _____

Print Name Date

X _____

Patient Signature

Debora Barchilon, MD

55 East 87th Street
New York, NY 10128
Tel: 212 875 2025

Email: info@TheBarchilonCenter.com
Website: TheBarchilonCenter.com

Patient Contact Preferences

First Name: _____ Last Name: _____

How do you wish staff to address you? O First name only O Last name only

May the office state the doctor's name when calling you? O Yes O No

Which telephone number would you like the office to use when contacting you?

O Home:_____ O OK to leave Voice Mail

O Work: _____ O OK to leave Voice Mail

O Mobile: _____ O OK to leave Voice Mail

X

_____ _____

Patient Signature Date

Debora Barchilon, MD

55 East 87th Street
New York, NY 10128
Tel: 212 875 2025

Email: info@TheBarchilonCenter.com
Website: TheBarchilonCenter.com

Request for Medical Records

Date: _____

Patient Name: _____

Date of Birth: _____

I give permission to: _____

to release information concerning my medical condition and treatment including psychotherapy notes and substance abuse treatment by telephone, fax or in writing to Debora Barchilon, MD:

( ) Please send a copy of my records for:

( ) ALL DATES
( ) THE FOLLOWING DATES:

_____

to the address/fax above.

This authorization remains in force until revoked by me in writing.

_____ _____

Date of Consent **Signature of Patient**

Debora Barchilon, MD
55 East 87th Street
New York, NY 10128
Tel: 212 875 2025

Email: info@TheBarchilonCenter.com
Website: TheBarchilonCenter.com

Consent for Release of Information

Patient Name: _____

Date of Birth: _____

I give permission to Debora Barchilon, MD to release information concerning my medical condition and treatment, including psychotherapy notes, by telephone, fax or in writing to:

NAME:	ADDRESS:
_____	_____
_____	_____
_____	_____
_____	_____

This authorization remains in force until revoked by me in writing.

_____ _____

Date of Consent Signature of Patient