Insurance Information/Patient Agreement for Coverage

Name of Patient: _____
Date of Birth: _____
SSN: _____
Insurance Company: _____
Utilization Company (if applicable): _____
Name of Parent/Guardian/Spouse: _____
Relationship to Insured: _____
Membership Identification Number: _____
Group Identification: _____
Authorization Number: _____
Type of Insurance: __Medicare __HMO __PPO __Indemnity
__Workers Compensation – Date of Accident:_____

By providing the information above, I provide that I am the eligible member of this insurance plan. I am assigning my benefits to be paid directly to Dr. Dmitry Byk MD PA. I understand that I remain responsible for any and all payments for services rendered should my insurance fail to cover the charges.

_____ _____
Signature Date

FOR OFFICE USE ONLY

Insurance Verification:
Date of Call: _____ By: _____
Phone Number of Carrier/Network: _____
Claims Address: _____
_____
Attention: _____
Effective Date of Authorization: _____
Copayment Amount/Coinsurance Percent: _____
Deductible: _____
Verified Balance Amount of Deductible: _____
Other Notes: _____
_____

Dmitry Byk, MD PA

21110 Biscayne Blvd, Ste 304
Aventura, FL 33180
Phone: (305) 932-5500
Fax: (305) 935-0466

IMPORTANT DOCUMENT PLEASE READ

CANCELLATION / MISSED APPOINTMENT POLICY

Dr. Byk is committed to providing you with the most ethical and effective treatment possible. Therefore, he values every appointment that is scheduled and will reserve that date and time for you. This reservation, however, also preserves Dr. Byk's time and precludes him from scheduling other clients. Therefore, if you are unable to attend your appointment, we require that you call the office to cancel within 24 hours of the time of your appointment (Monday through Friday) during business hours. Self-pay patients who do not attend their scheduled appointment or do not cancel within 24 hours will be charged the full amount of the appointment. Patients with insurance will be charged the full amount of their co pay and the amount of the missed insurance payment.

Thank you for your cooperation and understanding.

I have read and acknowledge the cancellation/missed appointment policy.

Signature _____ Date _____

COVERAGE, AFTER HOURS, & EMERGENCY POLICY

Dr. Byk sees patients during the following office hours: Tuesday through Thursday from 8:45am through 4:15pm. Phone calls are taken by staff and may be answered by Dr. Byk Monday through Thursday 8am to 5pm and Friday from 8am to 3pm. Phone calls after these hours are answered by the service and will not be returned until regular business hours.

*Please understand that this office **does not** handle emergency appointments or emergencies over the phone. If you have an emergency, please call 911 or go to a local emergency department.*

Also, Dr. Byk *does not* have any physician coverage while he is away from the office. It is the sole responsibility of the patient to ensure that they have enough medication to make it to their next appointment. If you are prescribed medication and are running short due to missed appointments, because of scheduling appointments too far out, or other reasons, you can request refills during business hours. However, these requests may not be fulfilled. Please ensure that you speak with Dr. Byk about having enough medication to last until your next visit before you leave.

I have read and acknowledge the coverage, after hours, & emergency policy

Signature _____ Date _____

Dmitry Byk, MD PA, 21110 Biscayne Blvd, Ste 304, Aventura, FL 33180

Office Policy Notification, HIPAA Acknowledgement & Assignment of Benefits

HIPAA Compliance: In accordance with the Health Insurance Portability and Privacy Act of 1996 which requires documented proof of acceptance of the office standards of privacy, this office provides all patients with a notice of the means of compliance with these HIPAA standards. According to the HIPAA laws, a patient can specify with whom their private medical information can be shared. It is the policy of this office that every patient must agree to allow this practice to share any necessary medical information with the following: the signed guarantor, patient's insurance company, third party administrator (insurance delegate), patient's attorney and this practice's attorney (only if/when necessary). If you do not agree to these terms, you may elect to pay for all services rendered out of pocket and submit your claim independently or we will gladly refer you to another office for your medical services. **Initial:** _____

Charges for Covered Benefits: Dmitry Byk, MD PA provides psychiatric services based solely on the belief in providing the finest patient care possible. As a result, at times these services may not be covered by certain insurance companies. The office will make all necessary attempts to recover reimbursement for these services directly from the insurance company. However, the patient is ultimately responsible for payment of services rendered. I understand and agree that I am responsible for charges for any services not covered by my insurance company when notified in advance that the services being provided are NOT covered. I further understand that I am responsible for any collection and/or attorney's fees if non-payment of the account results in it being turned over to a collection agency or attorney. **Initial:** _____

I understand it is my responsibility to obtain all necessary authorizations in accordance with my insurance's guidelines. I understand that my insurance does not guarantee payment regardless of authorization. Should my insurance deny payment, I am ultimately responsible for payment of services rendered. I understand and agree to make said payment upon notification either written or oral (at this office) – *(N/A for out of pocket paying patients)* **Initial:** _____

I understand that Dr. Byk only sees individual patients 18 years of age and older. *Due to many changes in insurance policies, we cannot be responsible for interpreting each individual policy. It is your responsibility to know your individual coverage and its limitations, as well as who is a provider for your plan. We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient being responsible for all costs incurred. Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to know to find out whether we are providers for your specific network.* I am aware and hereby agree that I am responsible for any portion of my bill that is not paid or covered by me. If I change my insurance carrier, I understand that it is solely my responsibility to notify this office prior to any visit that would be under that insurance. I acknowledge that the practice does NOT balance-bill or charge for prescriptions and any charges are for services rendered under valid procedures recognized by the AMA and APA in accordance with Medicare. **Initial:** _____

I hereby authorize Dr. Byk to provide any necessary treatment. In the event I am prescribed medication, I am responsible for assuring I have enough medication and/or appropriate quantities until my next appointment. I understand that if I miss a certain number of appointments or are not seen for a certain length of time, Dr. Byk may require an appointment before a new refill can be authorized. I understand that this notice serves as an assignment of my benefits to Dr. Byk and this shall remain in effect until I provide further notice that I am paying for these services in full or I am no longer being treated by Dr. Byk.

_____ _____

Signature Date

Dmitry Byk, MD PA

21110 Biscayne Blvd, Ste 304
Aventura, FL 33180
Phone: (305) 932-5500
Fax: (305) 935-0466

Dmitry Byk, MD PA Disclosure Statement:

Dear Patient,

Please be advised that Dmitry Byk, MD PA is under the ownership of Dmitry Byk, MD. This location is also the office for The Center for Counseling of Aventura, Inc, which is under the ownership of Lori Grabois, MD and Lee Pravder, MD. The Center for Counseling of Aventura has psychiatrists, psychotherapists, and psychologists that are independent practitioners within this office. Please be aware that Dmitry Byk, MD PA and The Center for Counseling are independent entities and are not controlled, affiliated, or have any supervisory roles with one another. Also, neither of these entities are responsible for the billing of the other.

This letter is intended for information purposes only. If you have any questions regarding this, please feel free to speak with the office manager.

I, _____, certify that I have read this disclosure statement.

_____ _____
Signature Date

_____ _____
Witnessed Date

Doctor: Dmitry Byk, M.D. Psychiatric Record

Patient ID: _____ Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ FL: ____ ZIP: _____

Primary Phone: ( ) _____ Secondary Phone: ( ) _____ SSN: _____

Gender: _____ Marital Status: _____ Email: _____

Referred By: _____ Preferred Contact Number: ☐ Primary Phone ☐ Secondary Phone

Employer Name: Address:

In your own words, briefly state what brings you to the office to see the doctor?

Previous Psychiatric History

Have you ever been…	to a psychiatrist(M.D./D.O.)?	to a psychologist/therapist(PhD/PsyD/LCSW/LMHC)?	Been in a psychiatric hospital
Who?			
When?			
Where?			
Reason?			

Have you ever been on psychiatric medications other than what you're on now(i.e. antidepressants, antianxiety, antipsychotics, etc…)?

Name of medicine	Dose	Times per day	How long were you on it?	Why did you stop?

Substance Use History

Do you now or have you in the past ever drank alcohol or smoked cigarettes?

Alcohol Age 1st used _____ Last time used: _____ How much used: _____ How often: _____

Cigs Age 1st used Last time used: How much used: How often:

Do you now or have you in the past ever used an illegal drug or used a prescribed medication more often than it was prescribed?

Substance Used:
Age at first use: Last time used: How much used: How often:

Substance Used:
Age at first use: Last time used: How much used: How often:

Substance Used:
Age at first use: Last time used: How much used: How often:

Substance Used:
Age at first use: Last time used: How much used: How often:

Family Psychiatric History

Has any blood relative in your family been seen by a psychiatrist or psychologist? Yes ___ No ___

Has any blood relative in your family been in a psychiatric hospital? Yes ___ No ___

Has any blood relative in your family attempted or completed suicide? Attemped ___ Completed ___

Has any blood relative in your family had in the past or currently have any of the following diagnoses?

___ Major depression ___ PTSD ___ Generalized Anxiety Disorder ___ Schizophrenia ___ Alzheimer's Disease ___ Borderline Personality Disorder

___ Other psychiatric issues

Medical History

Do you have any of the following medical problems? Current Primary Care Physician: _____

☐ atrial fibrillation ☐ anemia ☐ arthritis ☐ coronary artery dz ☐ high cholesterol ☐ CHF ☐ COPD ☐ diabetes I or II

☐ acid reflux disease ☐ high blood pressure ☐ hypothroidism ☐ previous heart attacks ☐ osteoarthritis or osteoperosis ☐ parkinson's dz

☐ epilepsy/seizures ☐ cancer: type _____ ☐ TIA or Stroke

Any other medical problems not listed? _____ Allergies to Medications:

What medications are you currently taking(list all including psychiatric and medical)? Or provide a list separately

Name of medication	Dose	How many times per day	How long have you been on it	Doctor that started the medication

Please Sign: