Fairway Psychiatry
Evan L. Jacobson, M.D.
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Document 1
>New Patient Information
>Informed Consent for Treatment
HIPAA acknowledgement
>Good Faith Estimate

NEW PATIENT INFORMATION

Date_____ **Referred by**_____

Legal Name_____

Date of Birth_____ **SS#**_____

Primary Address_____

City/State/Zip_____

Second Address_____

City/State/Zip_____

Cell Phone_____

Home Phone_____

Email Address_____

Emergency Contact (Required)_____

Relationship_____

Phone number of Emergency Contact_____

Address of Emergency Contact_____

City/State/Zip_____

INFORMED CONSENT FOR TREATMENT
AND HIPAA ACKNOWLEDGEMENT

I, **(Print Name)—>**_____, have reviewed the information in the HIPAA and Informed Consent Documents. I fully understand this information and agree to abide by its terms. I authorize Evan L. Jacobson, M.D. to provide psychiatric evaluation and medication and/or therapy treatment services for myself. Treatment will be conducted in a confidential manner, as stated under the HIPAA Regulations. The disclosure of confidential information will not be done unless authorized in writing. I understand that Dr. Jacobson is obligated by Florida Statutes 827.03 and 394.451-394.892 to report any suspiciousness of child abuse and/or neglect or if they demonstrate potential to cause harm to self or others requiring a Baker Act. In addition, I understand that Dr. Jacobson must report to the local Health Department any HIV status/infection or potential infection to a partner that the patient has identified pursuant to Florida Statute 456.061(1), F.S. and Rule 64D-2.00.(2)(l), F.A.C.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Jacobson if I have a change in health. I have had my questions answered to my satisfaction. I understand this agreement can be withdrawn at any time.

I consent to treatment by Dr. Jacobson.

Print Name_____

Signature_____**Date**_____

Evan L. Jacobson, M.D._____**Date**_____

GOOD FAITH ESTIMATE

Initial Evaluation	$300.00- $450.00 (typically 45-90 minutes)
Up to 50 min session	$350.00
Up to 30 min session	$250.00
Up to 20 min session	$190.00

Financial Responsibility:
Dr. Jacobson will send appointment confirmation and reminders via phone calls or text message as a courtesy only. It is the patient's responsibility to keep track of scheduled appointments. Appointments canceled with less than 48 hours notice are billed missed appointments. Typically insurance companies will not reimburse missed appointments. Typically Dr. Jacobson will send a payment request for the appointment fee prior to the appointment. Payment is due by the time of each visit via cash, check, credit card, Paypal, Square or Zelle. The fee for returned checks is $30. Dr. Jacobson has opted out of Medicare and is considered an out-of-network provider with insurance companies.

Other Service Charges:
There will be a charge for the preparation of forms, reports ($50.00 per document) and letters ($50.00 per letter) related to the services provided at this office. With few exceptions, the fees for the completion of these documents will be the responsibility of the patient. All photocopies and requests of the patient's medical records will be charged $25.00. Any changes made to the service fees will be informed to patients in advance.

Print Name_____

Signature_____Date_____