

**Marshall Teitelbaum, MD**  
**641 University Blvd., #206**  
**Jupiter, FL 33458**  
**561-630-8530**  
**Fax: 561-630-8531**  
**Doctortjupiter.com**

**Fill out and mail, fax or upload us your completed forms. We must have all forms prior to booking your appointment.**

*Dear Patients/Families,*

First, **welcome to my practice.** The following is a brief overview of the office.

My goal is to serve patients with consideration and respect. To allow my office staff to meet your needs, you may reach the office via phone from **9:30am-noon Monday - Friday, and 1:00pm - 3:30pm Monday - Thursday.**

During the time direct access to the office is not available, only calls of an emergent nature will be received. These may include severe medication reactions, suicidal or homicidal feelings, psychotic symptoms or a sudden extreme change to the patient's overall function. If it is felt that the situation requires emergent care prior to speaking to me, please go to the emergency room immediately to ensure safety of self and others.

**Medication refill requests are not considered to be emergencies and must occur during regular business hours.**

**Cancellation policy:** As a courtesy, my office makes every effort to text a reminder of your appointment. If you are unable to keep your appointment, two full business day's notice is required to avoid a cancellation fee. You may call or fax to accommodate any needs, including those about scheduling or clinical care.

I appreciate you giving me the opportunity to assist in the care of your family and/or you.

Sincerely,



Marshall Teitelbaum, MD



**TREATMENT/PATIENT AUTHORIZATION:** THE UNDERSIGNED AUTHORIZES MARSHALL TEITELBAUM/PROFESSIONAL STAFF TO ADMINISTER PSYCHIATRIC TREATMENT. I UNDERSTAND THAT I MAY BE CHARGED FOR AN OFFICE VISIT IF A SCHEDULED APPOINTMENT IS NOT CANCELED AT LEAST 24 BUSINESS HOURS PRIOR TO THE APPOINTMENT TIME OR MY ARRIVAL TIME FOR A SCHEDULED APPOINTMENT IS DEEMED TO BE TOO LATE TO BE SEEN.

AFTER THE INITIAL EVAL AND FIRST FOLLOW-UP APPOINTMENTS HAVE TAKEN PLACE, DR. TEITELBAUM REQUIRES AT LEAST QUARTERLY VISITS TO MAINTAIN A PROPER STANDARD OF CARE. A POSSIBLE DISCHARGE FROM THE PRACTICE COULD RESULT IF THREE (3) OFFICE VISITS ARE MISSED DUE TO NONCOMPLIANCE OF TREATMENT AND ELEVATED MALPRACTICE RISK.

**LEGAL ISSUES:** I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT ON ANY LEGAL ISSUES SUCH AS DEPOSITIONS, CHART REVIEW, PAPERWORK OR COURT APPEARANCES AT A BILLING RATE OF \$\$825 PER HOUR.

**PAYMENT OF SERVICES:** I AM AWARE THAT DR. TEITELBAUM DOES NOT ACCEPT OR FILE INSURANCE PLANS. PAYMENT IS REQUIRED IN FULL AT THE TIME OF EACH VISIT VIA CASH, CREDIT CARD OR CHECK. IF A CHECK IS RETURNED, THE FEE IS \$40.00

I UNDERSTAND IF I HAVE AN UNPAID BALANCE TO MARSHALL TEITELBAUM, M.D. AND DO NOT MAKE SATISFACTORY PAYMENT ARRANGEMENTS, MY ACCOUNT MAY BE PLACED WITH EXTERNAL COLLECTION AGENCY. I WILL BE RESPONSIBLE FOR REIMBURSEMENT OF THE FEE OF ANY COLLECTION AGENCY, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 35% OF THE DEBT, AND ALL COSTS AND EXPENSES, INCLUDING REASONABLE COLLECTION AND ATTORNEY'S FEES INCURRED DURING COLLECTION EFFORTS.

IN ORDER FOR MARSHALL TEITELBAUM, M.D. OR THEIR DESIGNATED EXTERNAL COLLECTION AGENCY TO SERVICE MY ACCOUNT AND WHERE NOT PROHIBITED BY APPLICABLE LAW, I AGREE THAT MARSHALL TEITELBAUM, M.D. AND THE DESIGNATED EXTERNAL COLLECTION AGENCY ARE AUTHORIZED TO (I) CONTACT ME BY TELEPHONE AT THE TELEPHONE NUMBER(S) I AM PROVIDING, INCLUDING WIRELESS TELEPHONE NUMBERS, WHICH COULD RESULT IN CHARGES TO ME, (II) CONTACT ME BY SENDING TEXT MESSAGES (MESSAGE AND DATA RATES MAY APPLY) OR EMAILS, USING ANY EMAIL ADDRESS I PROVIDE AND (III) METHODS OF CONTACT MAY INCLUDE USING PRE-RECORDED/ARTIFICIAL VOICE MESSAGE AND/OR USE OF AN AUTOMATIC DIALING DEVICE, AS APPLICABLE.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION TO LEAVE MESSAGES**  
**Marshall Teitelbaum, M.D.**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Dear Patient:

We would like to make your life easier. For your convenience, we will text/phone you to remind you of your appointments and respond to any messages you leave for the office. There may also be instances when the doctor needs to change your appointment. To protect your confidentiality, your permission is needed to leave a message with anyone other than yourself.

Please circle your choices:

Spouse      Relative      Friend      Answering machine

Person's name: \_\_\_\_\_

\_\_\_\_\_  
Signature - Patient, Parent or Guardian

\_\_\_\_\_  
Date

**I DO NOT GIVE PERMISSION TO LEAVE MESSAGES**  
**(circle if this is your choice)**

\_\_\_\_\_  
Signature - Patient, Parent or Guardian

\_\_\_\_\_  
Date

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I hereby authorize and request  
**Marshall Teitelbaum, M.D.**  
641 University Blvd., Suite 206  
Jupiter, FL 33458  
561-630-8530  
Fax: 561-630-8531

To release confidential professional information, including person, psychological, psychiatric, substance abuse, AIDS-related information, and medical records and opinions resulting from my contacts with them to: **(PLEASE WRITE IN INFORMATION FOR WHO YOU WANT US TO CONTACT)**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

This request specifically includes the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Psychological testing |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Psychosocial History  |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Other                 |

Dates to be covered by reports: From: \_\_\_\_\_ To: \_\_\_\_\_ I also authorize \_\_\_\_\_ (or one of his/her associates) to communicate with \_\_\_\_\_ regarding all aspects for my treatment, diagnosis and prognosis.

**I UNDERSTAND THAT I HAVE NO OBLIGATION TO DISCLOSE THE REQUESTED INFORMATION AND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY INFORMING ANY OF THE ABOVE NOTED INDIVIDUALS. IN CONSIDERATION OF THIS CONSENT, I HEREBY RELEASE THE ABOVE PARTIES FROM ANY AND ALL LIABILITY ARISING THEREFROM.**

\_\_\_\_\_  
Please print patient's name here

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature - Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Marshall Teitelbaum, M.D.**  
**641 University Blvd., #206**  
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**Fax: 561-630-8531**

**Tax ID - 65-1120940**  
**NPI # - 1336241207**

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Dr. Teitelbaum's fees are as follows:

Initial evaluation	\$525
One hour appointment	\$495
30 minute follow up (most visits)	\$295

You will be charged at the time of each visit.

Please note we have a one business day cancellation policy. If you do not cancel with at least one business day's notice, you will be responsible for the full appointment fee.

If we are obligated to send your account to collections due to non-payment, you will be charged an additional fee that equals 35% of your balance, as well as all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

Dr. Teitelbaum's legal fees are charged at \$825/hour. This includes time spent on record review in addition to time spent in depositions, court, and time required out of the office.

We reserve the right to charge up to \$1.00/page for medical records and up to \$50 for a letter written by Dr. Teitelbaum. Form completion *may* also incur an expense based on the required time needed proportionately to follow-up appointment rates.

*These fees do not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.*

\_\_\_\_\_  
Print patient Name

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Signature - patient, parent or guardian

\_\_\_\_\_  
Date

## **Disclaimer**

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

## **If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.**

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises)

**For questions or more information** about your right to a Good Faith Estimate or the dispute process, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises)

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

## **You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost**

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises)

Marshall Teitelbaum, M.D.

**Medical and Developmental History**

**1. Medical History:**

Current medications/dosages:

Drug allergies, including type of reaction seen:

History of previously performed surgery, including dates:

History of fractures, stitches, or other significant accidents:

History of seizures, head injuries or loss of consciousness:

History of heart problems *for patient or close relatives*:

Medical tests performed, including bloodwork, over the last year:

For women, is there any possibility you may be pregnant or nursing at this time or expecting to be in the near future:

**2. Developmental History (for children and teens):**

Gestational age in weeks (ie premature, full- or post-term):

Birthweight:

Mother's medical problems during the pregnancy (ie medications used, substance use, illnesses , injuries):

Delivery method: vaginal or C-section

Length of labor in hours:

Early medical problems seen (ie jaundice, colic, hospitalizations, etc.):

Any developmental delays (ie onset of walking, talking, or potty training):

BDI

\*\*\*\*\*Date: \_\_\_\_\_

Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

This questionnaire consist of 21 groups of statements. After reading each group of statements carefully circle the number (0,1,2,or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.  
1 I feel sad.  
2 I am sad all the time and I can't snap out of it.  
3 I am so sad or unhappy that I can't stand it.
2. 0 I am not particularly discouraged about the future.  
1 I feel discouraged about the future.  
2 I feel I have nothing to look forward to.  
3 I feel that the future is hopeless and that things cannot improve.
3. 0 I do not feel like a failure.  
1 I feel I have failed more than the average person.  
2 As I look back on my life all I can see's a lot of failures.  
3 I feel I am a complete failure as a person.
4. 0 I get as much satisfaction out of things as I used to.  
1 I don't enjoy things the way I used to.  
2 I don't get real satisfaction out of anything anymore.  
3 I am dissatisfied or bored with everything.
5. 0 I don't feel particularly guilty.  
1 I feel guilty a good part of the day.  
2 I feel guilty most of the time.  
3 I feel guilty all of the time.
6. 0 I don't feel I am being punished.  
1 I feel I may be punished.  
2 I expect to be punished.  
3 I feel I am being punished.
7. 0 I don't feel disappointed in myself.  
1 I am disappointed in myself.  
2 I am disgusted with myself.  
3 I hate myself.
8. 0 I don't feel I am any worse than anyone else.  
1 I am critical of myself for my weaknesses or mistakes.  
2 I blame myself all the time for my faults.  
3 I blame myself for everything bad that happens.
9. 0 I don't have any thoughts of killing myself.  
1 I have thoughts of killing myself but I would not carry them out.  
2 I would like to kill myself.  
3 I would kill myself if I had the chance.
10. 0 I don't cry any more than usual.  
1 I cry more now than I used to.  
2 I cry all the time now.  
3 I used to be able to cry but now I can't cry even though I want to.
11. 0 I am no more irritated now than I ever was.  
1 I get annoyed or irritated more easily than I used to.  
2 I feel irritated all the time now.  
3 I don't get irritated at all by the things that used to irritate me.
12. 0 I have not lost interest in other people.  
1 I am less interested in other people than I used to be.  
2 I have lost most of my interest in other people.  
3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as could.  
1 I put off making decisions more than I used to.  
2 I have greater difficulty in making decisions than before.  
3 I can't make decisions at all anymore.

Subtotal \_\_\_\_\_ Page # 1 Continued on next page

14. 0 I don't feel I look any worse than I used to.  
 1 I am worried that I am looking old or unattractive.  
 2 I feel that there are permanent changes in my appearance that make me look unattractive.  
 3 I believe that I look ugly.
15. 0 I can work about as well as before.  
 1 It takes an extra effort to get started at doing something.  
 2 I have to push myself very hard to do anything.  
 3 I can't do any work at all.
16. 0 I can sleep as well as usual.  
 1 I don't sleep as well as I used to.  
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.  
 3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get more tired than usual.  
 1 I get tired more easily than I used to.  
 2 I get tired from doing almost anything.  
 3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.  
 1 My appetite is not as good as it used to be.  
 2 My appetite is much worse now.  
 3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.  
 1 I have lost more than 5 pounds.  
 2 I have lost more than 10 pounds.  
 3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes \_\_\_\_\_ No \_\_\_\_\_

20. 0 I am no more worried about my health than usual.  
 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.  
 2 I am very worried about physical problems and it's hard to think of much else.  
 3 I am so worried about my physical problems that I cannot think about anything else.
21. 0 I have not noticed any recent change in my interest in sex.  
 1 I am less interested in sex than I used to be.  
 2 I am much less interested in sex now.  
 3 I have lost interest in sex completely.

\_\_\_\_\_ Subtotal Page 2  
 \_\_\_\_\_ Subtotal Page 1  
 \_\_\_\_\_  
 \_\_\_\_\_ Total Score

## CONNOR'S RATING SCALE (CHILDREN)

Child Name: \_\_\_\_\_

Date \_\_\_\_\_

Completed By: \_\_\_\_\_

OBSERVATION	NOT AT ALL	JUST A LITTLE	PRETTY MUCH	VERY MUCH
<b>Inattention</b>				
1. Often Fails To finish things he or she starts				
2. Often doesn't seem to listen				
3. Easily Distracted				
4. Has Difficulty concentrating on school work Or other tasks requiring sustained attention				
5. Has difficulty sticking to a play activity				
<b>Impulsivity</b>				
1. Often acts before thinking				
2. Shifts excessively from one activity to another				
3. Has difficulty organizing work (this is not due to cognitive impairment)				
4. Needs a lot of supervision				
5. Frequently calls out in class				
6. Has difficulty awaiting turn in games or Group activity				
<b>Hyperactivity</b>				
1. Excessively runs about or climbs on things				
2. Has difficulty sitting still or fidgets excessively				
3. Has difficulty staying seated				
4. Moves about excessively during sleep or rest time				
5. Is always "on the go" or acts as if "driven by a Motor"				
<b>Peer Interaction</b>				
1. Fights, hits, punches, etc				
2. Is disliked by other children				
3. Frequently interrupts other children's activities				
4. Bossy, always telling other children what to do				
5. Teases or calls other children names				
6. Refuses to participate in group activities				
7. Loses temper often and easily				