Stephanie M. Marko, M.D., LLC
24100 Chagrin Blvd Suite 130
Beachwood OH 44122
P: 216-359-1097 F: 888-463-9759
Email: dr.stephanie.marko@gmail.com
Website: psychiatristcleveland.com

INFORMATION FOR NEW PATIENTS

Welcome to my practice. This sheet is intended to explain some of my policies and to answer some frequently asked questions. Please review it carefully and feel free to ask questions.

Contact: Phone: The best way to contact me is by calling the number listed above. If I miss your call, I will make every effort to return your call that same day. I check my messages regularly, including evenings and weekends. If an urgent issue arises after hours or on the weekend, please call and leave a message specifically indicating that you would like to be called back on the weekend (otherwise I return evening/weekend calls during the next business day). I will make every effort to return your call in a timely manner. In the case of an emergency in which you need to be seen right away, please call 911 or go the nearest emergency room. Email: I do use email for rescheduling appointments, but given that email is not a secure form of communication, I strongly recommend against disclosing sensitive personal information or discussing other clinical matter. Questions regarding medications and other clinical matters should be handled by phone or in-person. Please note that I do not check email as frequently as my voicemail so do not use email to reach me urgently—use my voicemail. Texting: I do not send/receive texts.

Appointments: I schedule appointments myself. You can either call or email me to schedule, reschedule, or cancel. Patients are seen by appointment only. Cancellations: As soon as you know you cannot make an appointment please let me know so that I may offer the time to someone else in need. The full fee is charged for appointments cancelled less than 48 business hours in advance. Late arrivals: If you arrive late for your appointment it decreases the amount of time we have together as the appointment must end as scheduled to allow me to others in need at their scheduled time. You will be charged for the full amount of your scheduled visit.

Payment and Fees: Appointments: You may pay for your appointment with cash, check, or credit card. Payment is due at the time of service. Any check returned for insufficient funds is assessed a service charge of $25. You will be asked to leave a confidential credit card on file that can be billed for appointments and for late cancellation/no-shows. Other professional services: These services include writing letter, writing treatment summaries, extended phone calls between appointments and such. Since most doctors do not bill for these services, they tend to limit their availability to you or raise the cost of their office appointments to cover their losses. I believe that it is fair and simple to charge per service based on an hourly rate. If you do not utilize these services, you are not paying for them but if you need me, I will be available. If a phone call last more than 10 minutes, you will be charged for a prorated appointment. You will not be billed for brief phone calls during normal business hours or phone calls related to scheduling or billing. Professional fees may also be billed to the credit card on file.

Prescription Policy: If I am prescribing medication to you, I will write your prescriptions at your appointment with quantities/refills intended to last until your next follow-up appointment. If you know you are going to run out of medications prior to our next appointment, leave me a message and I will call in enough medication to last until the next appointment, though for controlled substance, I do charge a $25 fee because of the increased monitoring/documentation required for these medications. If you are taking medications for ADHD, please note that these prescriptions cannot be called in. To be maintained on these medications, you must have an office visit every 2-3 months.

Insurance: I am considered an “out-of-network” provider. This means that you pay the full amount at the time of service. I will provide you with a receipt that will have the information you will need to file a claim with your insurance company if you choose to. You have the option to decide whether to involve your insurance company in your care, which puts you in control of the information you make available to your insurance company. Most insurance companies have out-of-network mental health benefits. I always recommend speaking with a customer service representative with your carrier to get the most current and accurate information.

Stephanie M. Marko, M.D. LLC
24100 Chagrin Blvd Suite 130
Beachwood, OH 44122
dr.stephanie.marko@gmail.com
p: 216-359-1097
f: 888-463-9759

New Client Intake Form for Dr. Stephanie Marko

Name:_________________________________ **Date:**___________________

Mailing Address: **Physical Address (if different):**

____ ____

____ ____

____ ____

May I send mail to the above address? **Y / N**

Telephone Numbers (Please provide only numbers at which you give me permission to call you):

Home: __________________________________ May leave a detailed message? ___yes ___*no

Work: __________________________________ May leave a detailed message? ___yes ___*no

Cell: ___________________________________ May leave a detailed message? ___yes ___*no

Date of Birth/Age:_____________________ **Relationship Status:** ____________________

Occupation: ____

Have you ever engaged in therapy before? Y / N **Worked with a psychiatrist? Y / N**

Contact Person in case of emergency: _________________________________
Telephone #:_______________

Primary Care Physician:_________________________________**Telephone#:**________________

Medical History:

- List any medical problems:

____

____

____

- Current Medications (or bring in full list):

____

____

____

- Allergies:____

- Hospitalizations (Medical, Psychiatric, Substance abuse- give place and year):

____

____

____

- Family history of: mental illness? ______Yes ______No
- Substance abuse? ______Yes ______No
- Suicide? ______Yes ______No Violent behavior? ______Yes ______No

- How often do you?

  Smoke _____never _____monthly _____weekly _____daily

  Drink alcohol _____never _____monthly _____weekly _____daily

  Use drugs _____never _____monthly _____weekly _____daily

Primary Insurance:
Insurance Plan Name:____
Insured Name:____________________________ Insured ID#____________________

How did you hear about Dr. Marko's services?____________________________________
____

What would you like to gain from working with Dr. Marko? What are your goals?

____

____

____

CONSENT FOR TREATMENT:
Your signature below indicates that you have read the "Information for New Patients" sheet and agree to its terms and also serves as an acknowledgement that you have reviewed the HIPAA notice form.

______________________________________ ____________
Signature of Client (or Guardian if under 18) Date

_________________________ _______________________
Printed Name Stephanie Marko, M.D.

CREDIT CARD PAYMENT FOR PROFESSIONAL SERVICES

___ VISA ___ Mastercard ___Discover

____
Name on Account (exactly as it appears on credit card)

____
Address (if different from the 1st page)

________________________ ___________
City ZIP Code

____________________________ _________ __________
Credit Card Number Exp. Date 3 Digit Security Code
(on the back of the card)

I authorize Dr. Marko to bill the above credit card for professional services.

_________________________________ ___________
Signature of Card Holder Date

PAYMENT FOR LATE CANCELLATION OR NO-SHOW

I authorize Dr. Marko to bill the above credit card when I do not give advanced notice for a late (less than 48 business hours) cancellation or no-show, as per the "Information for New Patients" sheet. I understand that if I do not wish my credit card billed for this purpose, I am still responsible for paying these fees.

_________________________________ ___________
Signature of Card Holder Date