Thomas Finch, M.D.

80 8th Ave, Suite 1308
New York, NY 10011
Phone: (646) 779-7796

Office Policies

For initial visits, fees are due and payable 24 hours in advance to confirm the appointment. For follow up visits, fees are due and payable upon completion of the visit, unless prior financial arrangements have been made.

This office does not deal directly with insurance carriers. Your statement will include all of the information necessary for insurance claims. We suggest that you submit the claim as soon as you receive the statement and keep a copy for your records.

Full session fee will be charged for cancelled or missed appointments unless 48 business hours notice has been given (i.e. an appointment scheduled for Monday at 2 pm would have to be cancelled by Thursday at 2pm in order for a charge not to be incurred). Alternatively, if an appointment can be rescheduled within the calendar week, no fee will be charged. It is required that a credit card or bank number be on file for each patient in the event of missed sessions or late payments.

For patients on medication, please allow two business days for a prescription refill if you will not be seeing Dr. Finch before running out of medication. Please state your full name, medication name, dosage, frequency and pharmacy telephone number in your message.

In the event of a medical emergency, if you are unable to reach Dr. Finch, you should proceed to the nearest emergency room or call 911.

I agree to the above office policies.

Signature: _____
Print Name: _____
Date: _____

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Authorization for Release of Information

Patient's name: _____

I hereby authorize Dr. Thomas Finch, M.D., to contact and obtain and/or provide my medical and psychiatric history and other related information from/to the following people (please include current or prior therapist, if relevant, particularly if this is for a medication consultation):

Name:	Telephone:
_____	_____
_____	_____
_____	_____

I understand that this correspondence may involve a conversation or a transfer of written material and that I have the right to revoke the above authorization at any time.

Signature: _____
Printed Name: _____
Date: _____

NOTICE OF CONFIDENTIALITY

It is understood and agreed to by the recipient of the document or communications requested above that this is privileged information within the doctor-patient relationship, and is confidential material by law. Further disclosure or release of the documents or their contents by the recipient of any other party is not authorized without the above patient's written consent. Furthermore, it is understood that the patient may withdraw his/her consent to this release at any time.

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Patient Information

PATIENT INFORMATION

Patient Name: _____

Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone Number : _____

Backup Phone Number: _____ Email: _____

Emergency Contact Name/Relationship/Phone Number: _____
_____

Allergies: _____

Medical Problems: _____
_____

Current Medications (and Doses): _____
_____
_____

Pharmacy Name, Address, and Phone Number:
_____
_____