SINAN DUZYUREK, MD, PLLC

MR #:_____
(*Office Use*)

PATIENT INTAKE FORM

DATE OF INITIAL VISIT:_____ SOCIAL SECURITY #:_____

PATIENT'S FULL NAME:_____ GENDER:_____

DATE OF BIRTH:_____ PLACE OF BIRTH:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME TEL #:_____MOBILE PHONE #:_____ EMAIL:_____

EDUCATIONAL BACKGROUND:_____

EMPLOYMENT:_____

EMPLOYER'S (or SCHOOL'S) NAME:_____

WORK ADDRESS:_____

WORK PHONE:_____ HOME/WORK FAX #:_____

ALL HEALTH INSURANCE CO. NAMES, ADDRESSES AND PHONE NUMBERS (INDICATE the PRIMARY):

_____

_____

COVERAGE EFFECTIVE DATE:_____ INSURANCE ID#:_____

ARE YOU COVERED THROUGH *YOUR OWN* INSURANCE? YES:_____ NO:_____ If No, please provide the info below

INFORMATION ON "THE INSURED" (if you are insured through your significant other, indicate his or her info here):

Name:_____ Date of Birth_____

INSURED'S SOCIAL SECURITY NUMBER_____

INSURED'S ADDRESS:_____

_____

DO YOU HAVE MEDICARE? YES:_____ NO:_____ If yes, Medicare Plan &#:_____

2440 M Street, N.W.
Suite 413
Washington, D.C. 20037

PHONE (202) 466-3966
FAX (202) 466-4005
Website: www.malesexualfunctionhelp.com
www.DuzyurekMD.com

PATIENT INTAKE FORM (CONT'D)

SEXUAL ORIENTATION (Optional: May be left blank)

HETEROSEXUAL:_____ BISEXUAL:_____ GAY/LESBIAN:_____ NOT SURE or QUESTIONING:_____

PREFER NOT TO DISCLOSE:_____ OTHER:_____

CURRENT RELATIONSHIP STATUS

SINGLE:_____ MARRIED:_____ (MONTHS / YEARS IN MARRIAGE:_____)

DOMESTIC PARTNERSHIP:_____ OTHER Long-Term RELATIONSHIP:_____

DIVORCED:_____ WIDOWED:_____ SEPARATED:_____ OTHER:_____

NUMBER OF CHILDREN:_____ AGES OF CHILDREN:_____

WHO IS SHARING YOUR RESIDENCE WITH YOU?:_____

SOURCE OF REFERRAL (Check all that apply)

MY PRIMARY PHYSICIAN:____ OTHER HEALTH PROFESSIONAL:____

OTHER MENTAL HEALTH PROFESSIONAL:___ FRIEND:___ FAMILY MEMBER:___ INSURANCE Co:____

SELF-REFERRED USING: PHONE BOOK:___ INTERNET:___ AD IN THE MEDIA:___ OTHER:_____

IF REFERRED BY A PROFESSIONAL OTHER THAN YOUR PRIMARY CARE PHYSICIAN (therapist, lawyer, etc), PLEASE INDICATE HIS/HER NAME & CONTACT INFO:

_____

_____

_____

_____

PRIMARY CARE PHYSICIAN

NAME:_____

ADDRESS:_____

_____

PHONE:_____ FAX:_____

EMERGENCY CONTACT(S)

In the case of a life-threatening emergency, I authorize Sinan Duzyurek, MD or his staff to contact the following relative(s), friend(s), or significant other(s). I understand that this authorization is limited to emergency situations.

EMERGENCY CONTACT 1:

First Name:_____ Last Name:_____

Relation to patient:_____

Phone Number(s):_____

Address:_____

_____

Other means to reach this person (email/fax/pager, etc_ optional):

_____

EMERGENCY CONTACT 2:

First Name:_____ Last Name:_____

Relation to patient:_____

Phone Number(s):_____

Address:_____

_____

Other means to reach this person (email/fax/pager, etc_ optional)

_____

PATIENT'S FULL NAME:_____

SIGNATURE:_____ DATE:_____

SINAN DUZYUREK, MD, PLLC

PAYMENT AGREEMENT

A. Please Indicate Who Will Be Responsible For Patient Bills:

SELF _____ OTHER _____ If you checked OTHER, please fill in the information below:

Name:_____ Relationship to patient:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone number(s):_____

Fax (optional): _____ Email :_____

I accept full responsibility for patient bills.

Signature:_____ Date:_____

B. PAYMENT OPTIONS

All applicable fees are *due at the time of service*. Late cancellation or missed appointment fees are to be paid at the following scheduled session or in no later than one month, whichever comes first. Contact Dr. Duzyurek regarding payment arrangements for other professional services such as preparation of reports and other documents. You may pay in cash, with check or using your MasterCard or Visa. No other types of credit cards are accepted.

_____1. I wish to pay by credit card at each visit, though at times I may also pay by check or in cash. If I do not have my credit card with me for swiping (which is the preferred method), or if a balance exists at the end of each month, I authorize Dr. Duzyurek to bill that amount to the MasterCard or Visa account listed on the next page (*please fill in the credit card info on the next page*).

_____2. I wish to pay by check or in cash at the time of each visit, though at times I might also use a swiped VISA or MasterCard. In the event a balance exits at the end of each month, I will pay in cash or by check, in person or via mail. (If you also wish to authorize Dr. Duzyurek to bill any outstanding balance at the end of each month to a Visa or MasterCard account as an additional option, please fill in the credit card info on the next page.)

Signature: _____ Date: _____

CREDIT CARD INFORMATION (This Information Is Kept Confidential)

Card Holder's Name:_____

Street Address: _____

City:_____ State:_____ Zip:_____

Type of Credit Card: MasterCard_____ Visa_____

Card Number:_____

Exp. Date: _____ 3-digit CVV Code:_____

CREDIT CARD AUTHORIZATION: I authorize Dr. Duzyurek to keep my signature in my confidential file, and to charge my credit card according to the terms of the payment plan I agreed upon on the preceding page of this document. I understand that this authorization is valid until the credit card expiration date, unless I cancel it through written notice.

Signature:_____ Date:_____

INSURANCE RELATED POLICIES

Dr. Duzyurek is an *out-of-network provider with all private insurance plans*, and you will be responsible for payment in full at the time of visit or per the payment agreement above. Dr. Duzyurek will provide you with a statement (patient bill) containing information necessary for you to file with your insurance company for a re-imbursement according to your insurance policy. Dr. Duzyurek does not file claims with insurance companies. You are responsible for checking with your insurance company to obtain information on your benefits and for informing Dr. Duzyurek about any requirement for prior authorization or periodic precertification for ongoing treatment.

Sinan Duzyurek, MD, PLLC does not guarantee benefits or payment by your insurance company.

Sinan Duzyurek, MD, PLLC does not participate in Medicaid or Medicare, and is not able to see anyone under these forms of insurance.

I fully understand the above policies set forth by this office will not be adjusted. My signature below indicates that I have read, I do understand and agree with the policies above.

Patient's/Guardian's Full Name:_____

Patient's/Guardian's Signature:_____ Date:_____

SINAN DUZYUREK, MD, PLLC

AUTHORIZATION OF RELEASE OF HEALTH INFORMATION TO THE INSURANCE COMPANY/COMPANIES

I hereby authorize Sinan Duzyurek, MD, PLLC to disclose information on my diagnoses, functioning level, prognosis, treatment goals and plans, the types of treatment I am receiving, and any other clinical or procedural information that may be requested by my insurance company or companies in order for them to consider to authorize, pay or reimburse for the services rendered or to be rendered by Dr. Duzyurek.

I understand that I may revoke this authorization at any time, and that doing so may result in my inability to utilize my insurance. I also understand that the release of this information to my insurance company does not guarantee payment by them.

I understand that:

1. I have the right to inspect my records of mental health information.
2. The mental health professionals responsible for my diagnosis and/or treatment may refuse to disclose or may limit disclosure of my mental health information [pursuant to the District of Columbia Mental Health Information Act. D.C. Code 6-200 I. et sec].
3. This information cannot be redisclosed without my specific written consent under Federal regulation (42 C.F.R. Part 2) or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The law of the District of Columbia also prohibits the redisclosure of this information and requires this notice:

"The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization by the client or as provided in Titles III or IV of the Act. The Act provides for civil damages and criminal penalties for violations."

Patient's Name:_____

Patient's/Guardian's Signature:_____ Date: _____

THERAPEUTIC CONTRACT

I understand that, given sufficient time and with full collaboration, sexual medicine treatment is often highly helpful, although it cannot offer guarantees. By fully collaborating with my doctor, my chances for improvement in my symptoms or problematic issues will increase. I understand that my doctor will rely on my cooperation with the diagnostic tests or procedures he may recommend, and the accuracy of my feedback and reporting on my symptoms, my behavior and events/situations taking place in my life between treatment sessions, my adherence to the prescribed medications or any other treatment regimen, and any side effects I might be experiencing with medications. I realize that if the accuracy of the information I provide on these is inadequate or compromised, in turn, this may seriously compromise my doctor's ability to help me professionally.

I agree to be completely open about any potentially dangerous or risky symptoms or behaviors, including (but not limited to) suicidal, homicidal, or violent urges, feelings, thoughts, or acts. I hereby contract with Dr. Duzyurek that if anytime in the future (for as long as I maintain a doctor-patient relationship with him) I experience any feelings, thoughts or urges to hurt myself or another person (or other people) with a possibility that I might act on them, I will seek help *immediately* by calling 911 or going to the nearest Emergency Room *without* acting on these feelings, thoughts or urges. After taking these immediate safety measures, I will also call/page Dr. Duzyurek, or ask the staff at the Emergency Room or hospital to contact him for clinical collaboration. I understand that my failure to follow this safety contract may have important consequences in terms of how my case will be handled by Dr. Duzyurek, and this may include referral to other treatment resources or facilities.

I consent to and voluntarily enter treatment with medications and/or psychotherapy and/or other behavioral or medical treatment modalities with Dr. Duzyurek, and agree to cooperate with treatment plans I make with my doctor and exert my best effort in working on my problems and their solutions. If for any reason I feel that I cannot cooperate with the treatment plan I will discuss the reasons why I cannot cooperate fully. In this latter instance, I will propose changes to the treatment plan or explore alternatives with my doctor, taking his professional input into consideration. I understand that under certain circumstances my doctor may have professional reservations about the changes to the treatment plan I may propose. I understand that, as a voluntary patient, I may terminate my treatment and doctor-patient relationship at any time I wish. I agree it would be preferable if my doctor and I can first confer about ending our doctor-patient relationship. I realize that there may be risks of premature termination of therapy. I also understand that my doctor may recommend terminating treatment under certain conditions such as a sub-optimal working relationship, recurrently disruptive or other compromising behavior, or missing or cancelling appointments too frequently (with or without advance notice). In addition, I realize that my treatment may be suspended or I may be provided with referrals to alternative resources and discharged from Dr. Duzyurek's practice should I have a patient payment due on my account.

Patient's/Guardian's Full Name:_____

Patient's/Guardian's Signature:_____ Date:_____

CONSENT TO RELEASE MEDICAL INFORMATION

In order to allow Dr. Duzyurek to provide other professionals involved in your care (such as your primary care physician, other medical specialists, or a therapist) with feed-back, and to coordinate various aspects of your care, please fill out and sign the appropriate consent form(s), either included in this package or available from your doctor. Ordinarily, this would include the professional that has referred you to Dr. Duzyurek's practice, if any. If you prefer, you may also give Dr. Duzyurek permission to communicate with other parties, such as a family member, friend, or a significant other.

AUTHORIZATION FOR BILATERAL DISCLOSURE OF CLINICAL INFORMATION

_____ , hereby give authorization to Sinan Duzyurek, M.D. to
Patient's Name - Please Print

exchange the following info:

☐ Clinical Assessments, Observations, and Diagnoses ☐ The Treatment Provided and Other Recommendations Made ☐ Prognosis ☐ Laboratory and Other Diagnostic Test Results
☐Other (Specify:_____)

with the following entities or individual(s):

_____
Recipient's Name - Please Print

_____
Address I

_____
Address 2

_____
Phone Number

_____

Fax Number

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1. I have the right to inspect my records of mental health information.
2. The mental health professionals responsible for my diagnosis and/or treatment may refuse to disclose or may limit disclosure of my mental health information [pursuant to the District of Columbia Mental Health Information Act. D.C. Code 6-200 I. et sec].
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_____	_____	_____
Signature of Patient	Date	Patient's Phone Number
_____	_____	_____
Signature of Parent or Legal Guardian	Date	Parent / Legal Guardian Phone Number