Christine A. Mitchell, D.O., P.L.L.C.
15 Parkway #2
Katonah, NY 10536
Office: (914) 507-2909 Fax: (914) 992-7457

PATIENTINFORMATION

_____
Name Date of Birth

_____
Street address City State Zip Code

_____
Home Phone Work Phone Cell Phone Email
Please consent by checking Yes __ or NO __ for automated appointment reminders and check your preference Text __ Email __ Both Text and Email __

_____
Marital Status Employment Status Social Security #

Preferred Language_____

Ethnicity (Circle One): Hispanic or Latino Non-Hispanic or Latino Decline to state

Race (Circle All That Apply):

African or African American Asian or Asian American

Caucasian or European American Native American or Native Alaskan

Native Hawaiian or Other Pacific Islander Other

Gender / Identity Preference _____ Pronouns _____

Referred by_____

PCP_____

PHARMACY

_____
Pharmacy Name Address Phone &/or Fax

Party you would like us to contact in case of emergency:

_____
Name, Address, Phone Number, & Relationship to Patient

Please Check

O I do not want any information about my healthcare communicated to family members/caregivers

O I give permission to communicate to: (Please list names) _____
Information that may be communicated (please ✓) O Prescription Request, O Appointments, O Billing O Mental Health, O Substance Abuse, O HIV/AIDS, O Other

The current office hours are generally Wednesday from 10:00 a.m. to 6:00 p.m. and Thursday 8:00 am to 5:00 p.m. You may leave a voice mail at the office phone number at any time, which will be answered by Dr. Mitchell as soon as she is able. If you have a medical emergency, you should go immediately to the nearest emergency room. Dr. Mitchell operates a fee-for-service practice and does not participate with any insurance carriers. She will provide you with documentation to help you obtain any reimbursement your insurance carrier may pay directly to you. She requires payment at the time of your visit. Dr. Mitchell has opted out of the Medicare program and all Medicare patients must sign a contract with her acknowledging this. Dr. Mitchell is not a primary care provider. Her focus is on providing Osteopathic Manipulative Treatments.

You are required to give a 24-hour notice if you will be unable to make an appointment. A $125.00 fee may be charged for any missed appointments. A $35.00 fee will be charged for a bounced check. If you, an insurance carrier or your attorney's office request your medical records from Dr. Mitchell, the fee for the preparation, printing, copying, and shipping and handling of your records is determined by state law. If an insurance carrier or attorney's office requests your records, our office requires that the carrier or office provide signed documentation from you authorizing the release of your information. Dr. Mitchell does not testify in court. She does not take worker's compensation cases but can provide services if referred.

We typically text or email reminders/confirmation for appointments. Please consent and check preference above.
I understand that a message may be left for me at the above phone numbers.

I authorize Christine A. Mitchell, DO to release any individually identifiable health information about me needed for treatment, payment, to process insurance claims and healthcare operations.

Dr. Mitchell understands that you have come here to seek specialized treatment and she will endeavor to assist you in a speedy recovery, but of course she cannot guarantee any specific result. By signing below, I signify that I have read and understand the notice of privacy practices for this office as well the contents above.

_____

Patient Signature/Legal Guardian DATE