

Initial Contact Form

Dr Moazen Psychiatry

First and Last name: *

Date of Birth (mm/dd/yyyy): *

Phone number: *

Email: *

How did you learn about my practice? *

Through a friend

Through a provider

Online search

What are you seeking help for? *

Are you currently in psychotherapy and/or taking a psychiatric medication? *

Both

Only psychotherapy

Only medication

None

Have you ever had any suicidal thoughts (either past or present)? *

Yes

No

Have you ever been hospitalized psychiatrically? *

Yes

No

Do you use any of the following substances more frequently than once a day? *

☐ Alcohol

☐ Cannabis

☐ Nicotine

☐ Opioids

☐ Stimulants (non-prescription)

☐ None

Do you have health insurance in the USA? *

Yes

No

If yes, what insurance company/plan?

UMR Top Tier

Medicaid

Aetna New School

Other (specify)

Medicare

I am aware that Dr. Moazen Psychiatry is out-of-network with all other insurance plans (besides Mount Sinai UMR Top Tier and Aetna New School). This means that I am willing to pay for services at time of service and submit super bills to my insurance to be reimbursed directly. *

Yes

No

I am open to tele-health/virtual visits? *

Yes

No

I am able to be physically located in New York State or New Jersey at the time of my visits? *

Yes

No