New Awakening
Mental Health

Anshuman “Tony” Jyoti, MD
8575 Fern Ave, Suite 106
Shreveport, LA 71105
P: 318-828-2647
F: 318-670-8451

Patient Contract and Office Policies

****Please read carefully****

- The information I have provided is true to the best of my knowledge.
- If any of my demographic information changes, it is my responsibility to inform the office to maintain adequate care with my provider.
- I am aware that the office may call to confirm appointments as a courtesy, but it is ultimately my responsibility to keep up with my appointment dates.
- **I understand that it is my responsibility to inform the office at least 24 hours prior to my appointment if I am unable to keep it for any reason. Because of this policy, I will be charged a missed appointment fee of $75.00. This charge cannot be submitted to my insurance company for payment.**
- I agree to arrive to my appointment on time. If I am late, I understand that the health care provider or office staff can cancel and/or reschedule my appointment.
- I understand that if I do not have insurance, the full payment is due at the time of service. If full payment is not received, I must reschedule my appointment.
- I understand that it is my responsibility to keep the office informed of any changes in my insurance policy.
- I understand that I may be responsible for any balance due after my insurance policy covers it is share of my office visit.
- I understand that New Awakening does not accept Medicare or Medicaid.
- I agree to comply with the treatment plan my provider has discussed with me.
- I agree to take all medications as prescribed by my provider. If I abuse any medications, I understand that I am subject to discharge.
- I agree to not obtain or take medications prescribed by an outside provider without knowledge or consent from my provider. If a pharmacy contacts the office to inform of multiple narcotic prescriptions, I am subject to immediate discharge from the clinic.
- I understand that the office staff will periodically pull reports from the Louisiana Board of Pharmacy’s Prescription Monitoring Program, to ensure each patient is being complaint with Dr. Jyoti’s treatment plant.
- Medications will not be filled early by the provider if the prescription runs out before the time of the next refill.

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- I understand that all medications are my responsibility, and I agree to keep them in a safe and secure place. **My provider is NOT responsible for any lost or stolen medication and prescriptions.** Lost or stolen medications will not be filled early.
- I am aware that there is a $15 charge per letter and/or form that I request the office staff and/or providers to complete and agree to pay at the time of service.
- I agree to treat the office staff that work as colleagues alongside my health-care provider with courtesy and respect. I understand that New Awakening has a zero-tolerance policy regarding rude and harassing behavior. This includes repeated phone calls requesting and/or demanding medications or early appointments and the use of profanity. Patients who exhibit this behavior in the opinion of Dr. Jyoti or the office staff will be subject to discharge from the practice immediately.

I, _____, have read and understand the patient contract and agree to comply. I understand that I can contact the office if I have any other questions.

_____ _____

Signature **Date**

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Intake Form

Please fill out all information to the best of your ability.

Reminder: If patient has a guardian, he/she must sign paperwork

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ Age: _____ SSN: _____ Gender: M / F

Street Address: _____ Apt or Box #: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

May we send you information at this email? ____ Yes ____ No

Cell Phone: (_____)_____ May we text, call, or leave a message at his #? ___ Yes ___ No

Home Phone: (_____)_____ May we text, call, or leave a message at his #? ___ Yes ___ No

Work Phone: (_____)_____ May we text, call, or leave a message at his #? ___ Yes ___ No

Primary Insurance: _____

Policy Holder’s Name: _____

Date of Birth: _____

Secondary Insurance: _____

Policy Holder’s Name: _____

Date of Birth: _____

Our office only takes BCBS. Please be aware of your insurance company’s policy on secondary insurance if we are not in-network. You will be responsible for charges accrued.

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___ Engaged

Emergency Contact: _____

Phone: _____ **Relationship to client**_____

I give consent to contact the above listed person in the event of an emergency. ___ Yes ___ No

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I give consent to contact the above listed person to coordinate my care. ___ Yes ___ No

Briefly describe what brings you to New Awakening Mental Health:

_____

_____

Referral for: ___ Mental Health ___ Substance Abuse ___ Worker's Compensation/ Legal

Referred by: ___ Self ___ Hospital ___ Family/Friend ___ School

___ Court ___ Attorney ___Physician

Name of referral (If applicable, DHS contact, probation officer, doctor):

_____

Medical/ Health Information

Have you received mental health treatment before? ___ Yes ___ No

If so, where: _____

When: _____

Have you been treated for alcohol/ drug abuse before? ___ Yes ___ No

If so, where: _____

When: _____

Who is your primary doctor/medical provider?

_____

Name **City** **Phone Number**

Which pharmacy do you use? _____

Street/Intersection: _____

Phone Number: _____

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Please list any current or ongoing medical problems:

_____

_____

_____

_____

_____

What medications do you take? (Include non-prescription, herbal medicines and supplements. Use back of page if not enough space.)

Medicine	Dose	Frequency	Prescriber

Please list any allergies and reactions, including medication allergies/sensitivities:

_____

_____

Client/ Guardian Signature: _____

Completed on: _____

Staff Signature: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. This notice will remain in effect until it is amended or replaced by our office.

We reserve the right to make any changes in our privacy practices and will make the notice available upon request.

You may notice a copy of our Privacy Notice at any time by contacting our office. Contact information can be found above.

GENERALIZED SUMMARY OF USES AND DISCLOSURES CONCERNING HEALTH INFOMRATION

New Awakening, LLC is committed to honoring the privacy and confidentiality of your health information. We have an ethical and legal obligation to protect the privacy of your health information and will only use or disclose it in limited circumstances. Your health information will be used only for the following purposes:

TREATMENT: We may use and disclose your health information to provide, coordinate, and manage your care. This may include consulting with other health care providers involved in your care.

WORKERS COMPENSATION: We may use and disclose your health information to representatives involved with your case. This includes but is not limited to your adjuster, case manager, and other persons involved.

PAYMENT: We may use and disclose your health information so that we may bill and collect payment for the services that we have provided to you. This involves our office staff and may include insurance organizations or other businesses that become involved in the process of mailing statements and/or collecting unpaid balances.

HEALTHCARE OPERATIONS: We may use and disclose your healthcare information to assist in the operation of our practice. For example, members of our staff may review or use your health record to assess the care and outcomes in your case others like it as part of a continuous effort to improve the quality and effectiveness of the health care and services.

EMERGENCIES/ RELEASE TO FAMILY AND FRIENDS: Our providers and staff, using our professional judgement, may use and disclose your health information to a family member, close friend, or anyone responsible for your care.

BUSINESS ASSOCIATES: We may disclose your health information to our business associates so that they can perform the job we have asked them to do. We do require them to appropriately safeguard your information.

TREATMENT OPTIONS/ ALTERNATIVES: We may use and disclose your health information to refer you/ inform you of alternative treatments.

LAW ENFORCEMENT: We may use or disclose your health information when we are required to do so by law including but not limited to:

- court orders, subpoenas, warrants, summons, or similar lawful processes
- to identify or locate a suspect or fugitive
- criminal conduct
- coroners or medical examiners
- emergency circumstances
- authorized federal official

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YOUR PRIVACY RIGHTS AS OUR PATIENT

ACCESS: Upon request, you have the right to inspect and get copies of your medical and billing information (and that of an individual for whom you are a legal guardian). Copies, if requested, will be $1.00 per page for the first 25 pages and $0.25 per page thereafter. Please contact Medical Records.

AMENDMENT: If you feel that your medical information in this office is incorrect or incomplete, you may ask us to amend the information. You must provide a valid reason for this request. In addition, New Awakening Mental Health has the right to deny your request if the health information.

- was not created by our office, unless the person or entity that created the information is no longer available to make the amendment
- is not part of the information which you would be permitted to inspect and copy
- is not part of the medical information kept by or for New Awakening Mental Health
- is accurate and complete

If we deny your request for amendment, you may submit a statement of disagreement, and it will be included in your medical records.

RESTRICTIONS: You have the right to request that we place additional restrictions or limitations on our use or disclosure of your health information including treatment, payment, or healthcare operations.

QUESTIONS AND COMPLAINTS

If you believe that we have not complied with our Privacy Policies, you may file a complaint with us or with the U.S. Department of Health and Human Services. All complaints must be submitted in writing within 180 days of when you knew or should have known alleged violation occurred. You will not be penalized for making a complaint.

HOW TO CONTACT US

New Awakening Mental Health
8575 Fern Avenue, Suite 106
Shreveport, LA 71105
Phone: 318-828-2647 Fax: 318-670-8451
newawakening8575@gmail.com

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this agreement
I have read a copy of this office’s Notice of Privacy Practices.

_____ _____
Signature Date

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Disability/ Legal/ Worker’s Compensation

Are you applying for Disability (SSI, SSD, SSDI, partial or full)?
___ Yes ___ No

Are you seeking work leave through FMLA?
___ Yes ___ No

***Dr. Jyoti does not handle or get involved in *most* legal issues, including but not limited to: disability determination, FMLA, or custody disputes. ***

**Dr. Jyoti does handle some Worker’s Compensation cases and personal injury disputes. Please have your attorney’s office contact our office staff for further information. *

My signature acknowledges that I have read the above statement.

_____
Signature

_____
Printed Name

_____
Date

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Payment Policy

Please read this policy carefully

- For cash pay patients, payments are due in full at the time of services. For insured patients, copayments and/or deductibles are due at the time of service. I understand that if I cannot provide payment in full on the day of my appointment, I will not be seen.

- I also understand that if I do not cancel my appointment at least 24 hours ahead of time or *no show*, I am required to pay an initial cancellation fee of $75.00.

- As a courtesy to the patients, the first no-show appointment is written off, but the fee is increased with each missed appointment. This fee **CANNOT** be filed on my insurance, as it was my responsibility to cancel the appointment in an appropriate amount of time.

- **I may not be able to receive medication refills with an open account balance.** If there was an emergency, supporting documents are to be submitted to the office within 5 business days, and the fee will be waived.

By signing below, I acknowledge my understanding of this policy.

_____

Printed Patient Name | Signature | Date

_____

Printed Staff Name | Signature | Date

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