Psychiatric Medical Associates, P.A. / NTBHA Affiliate
6404 International Pkwy, # 1010, Plano, TX 75093
Phone # 972-267-1988
Fax # 972-267-3434

Date: _____

Patient Name: _____ DOB: _____

Social Security # _____ Sex: ☐ Male ☐ Female

Email (for telemedicine/patient portal): _____

Ethnicity : ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown

Race : ☐ American Indian ☐ Asian ☐ Black / African American ☐ White ☐ Native Hawaiian ☐ Other

Address: _____

City: _____State: _____ Zip: _____

Home phone # _____ Cell # _____ Work # _____

Marital Status: _____ Spouse's Name: _____

Employer _____

In Case of an Emergency, who can we contact?

Name: _____ Phone # _____

Relationship: _____ Cell # _____

Can we release ALL personal health information to the following? (Please provide names)

☐ School Nurse / School Counselors: _____ ☐ PCP: _____

☐ Employer / HR Department: _____ ☐ Counselor / Therapist: _____

☐ Social Security Department _____ ☐ Doctor: _____

☐ Texas Dept. of Family and Protective Services-CPS ☐ Other: _____

☐ Attorney Office: If yes, please provide Attorney's name & phone # _____

Insurance Information:

Insurance company: _____ Member ID/ Policy # _____

Group # _____ Insurance phone # _____ Employer: _____

Name of Primary Policy Holder: _____ Primary Holder's DOB: _____

Primary Holder's SSN: _____ Relationship to Patient: _____

Is Primary Policy Holder the Responsible Party? ☐ Yes ☐ No (Adult patients are responsible for their own financials)

If No, Responsible Party / Guarantor's Information:

Responsible Party Name: _____Home/Cell Phone # _____

Address: _____

City: _____State: _____ Zip: _____

Patient/Guardian Signature: _____ Date: _____

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ASSIGNMENT FOR BENEFITS

I, _____ authorize Psychiatric Medical Associates, P.A. to bill my insurance company for charges incurred during the course of my treatment and to provide any information necessary to process my claims and to collect payment. I authorize my insurance company to honor a photocopy of this authorization and to assign my insurance benefits for these charges to Psychiatric Medical Associates, P.A.

Sign: _____ Date: _____

Printed Name: _____

INFORMED CONSENT

Child / Adolescent Patients and/or Patients with Legal Guardians

If you are signing this Informed Consent as it relates to seeking services for a minor child/adolescent, please answer the following questions (providing names and relationship of each with the adolescent):

With whom (both parents, one parent, other) does the child/adolescent reside? _____

Who has legal custody of the child/adolescent? _____

I (We) _____, parent(s) / legal guardian of _____ accept the conditions for receiving services from Sejal Mehta, M.D., M.B.A. and the Nurse Practitioners. I (We) have received a copy of Psychiatric Medical Associates, P.A.'s Notice of Privacy Practice and policy and procedures.

Sign: _____ Date: _____

Printed Name: _____

TELEMEDICINE CONSENT

I, _____, agree to participate and give my consent for telemedicine consultations for psychiatric care including but not limited to psychiatric evaluations, medication management and psychotherapy. I also hereby agree to put a credit card on file for such visits and authorize Psychiatric Medical Associates, PA to charge my credit card on file for any co-pay, co-insurance and deductibles that may apply for the consultation.

Sign: _____ Date: _____

Printed Name: _____

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For Child / Adolescent patients

Patient's Name: _____

Sex: ☐ Female / ☐ Male Date of Birth: _____

Mother's Name: _____ Date of Birth: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married

Relationship to the patient:

☐ Parent ☐ Step-parent ☐ Legal Guardian ☐ Foster ☐ Personal Representative ☐ Adoptive Parent

Address: _____

City: _____State: _____ Zip: _____

Home phone # _____ Cell # _____ Work # _____

Employer _____

Father's Name: _____ Date of Birth: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married

Relationship to the patient:

☐ Parent ☐ Step-parent ☐ Legal Guardian ☐ Foster ☐ Personal Representative ☐ Adoptive Parent

Address: _____

City: _____State: _____ Zip: _____

Home phone # _____ Cell # _____ Work # _____

Employer _____

If Parents are divorced, who has custody of child? : _____

Can we release ALL personal health information to non-custodial parent? _____

Besides parent do you give permission for someone else to bring patient to the doctor's appointments? _____

Name: _____ Relationship to pt.: _____

If CPS is involved, please identify CPS caseworker name and number: _____

Are there any custody issues that your provider needs to be aware of? (If so please *briefly* explain): _____

_____

_____

_____

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Patient Name_____ Date_____

Chief Complaint or Reason for Visit_____

_____

_____

Past Hospitalizations and General Medical History: Please list any ongoing medical conditions, treating physician, and reason for any past hospitalizations _____

_____

_____

List all medications you are currently taking: Please include dosage if known _____

_____

_____

_____

Please list any medical allergies _____

_____

_____

Current or History of Alcohol/Drug use _____

_____

_____

Family Psychiatric History: Please identify relation and diagnosis _____

_____

_____

For Women Only: Possibility of Pregnancy? ☐ ***Yes*** ☐ ***No*** ☐ ***Maybe***

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Patient Questionnaire

Patient Name: _____ Date: _____

Are you currently seeing a therapist? Yes No Name: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

PLEASE CIRCLE WHICH ONE IF GIVEN 2 CHOICES:

	Not At all	Some days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating. (Circle)	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading a book or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual. (Circle)	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way. (Circle)	☐	☐	☐	☐

_____

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work / school, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient / Guardian Signature: _____ Date: _____

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Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Psychiatric Medical Associates, P.A. at 972-267-1988.

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4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Psychiatric Medical Associates, P.A./NTBHA at Fax # 972-267-3434. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact 972-267-1988. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

   If you have any questions regarding this notice or our health information privacy policies, please contact 972-267-1988.

I _____ authorize Psychiatric Medical Associates, P.A./ NTBHA to release all information regarding my treatment to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I hereby acknowledge that I have been presented with a copy of Psychiatric Medical Associates, P.A./ NTBHA's Notice of Privacy Practices.

_____ _____

Signature of Patent/Guardian Date

_____

Printed Name

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General Office Policies and Procedures & Financial Agreements

Thank you for choosing Psychiatric Medical Associates, P.A. to be of service to you and your family for your behavioral healthcare needs. Please read these policies completely, and if you have any questions, do not hesitate to ask for clarification.

Appointments: Appointments are scheduled according to each patient's needs and the availability of the provider. The time of your appointment is reserved for you. You are expected to give 24 hours' notice with a staff member or with the answering service if you will not be keeping your appointment, **or it will be necessary for you to pay an unkept appointment fee of $50.** Your insurance company will not cover this fee. It is your responsibility. Repeated "no show" or "late cancelled" appointments could result in you being referred out of the clinic to another practitioner. We do not do phone appointments. In case of an emergency, where you cannot come to your regular scheduled appointment and you have to do a phone appointment, you will be charged $135 for the appointment. We cannot bill your insurance for the phone appointments, it is your responsibility.

Maintaining Patient Status: In our area of healthcare, it is very important that you be seen on a regular basis. At the end of each appointment, the doctor / nurse will tell you how long a period of time they would like you to schedule a follow-up appointment in the office. We urge you to make the follow-up appointment before you leave our office in order to schedule the most convenient time for you. **If you fail to keep and/or maintain follow-up appointments for a period of 120 days or greater, we will conclude that you have terminated the patient-physician relationship**.

Phone Calls: Emergency calls are handled as a priority. If you are experiencing a medical emergency, please call 911 immediately. Routine calls will be handled by our office staff during our normal business hours. Please leave a message on our voice mail or with our after-hour's answering service for the office staff. Your call will be returned on the next business day. Calls that require the doctor to call you back will be handled as timely as possible. Please leave your name, number and detailed message with our 24 hours answering service if your call is urgent and cannot wait until the office is open. Medication refills/pre-authorizations/scheduling appointments **are not considered emergencies**, so please do not have the doctors paged for such services.

Medication Refills: We handle all refills during your regularly scheduled appointments. If a medication refill becomes necessary, please provide us with your pharmacy phone number, medication name and how you are currently taking your medication. We will require you to make an appointment, and we will call in enough medication to last until your appointment. **There is a $30 fee for medication refill requests between appointments.**

- **On the first appointment, prescription for 30 days will be given. We cannot give 90 day Rx on the initial visit.**
- Patients can be given 90 days Rx on their subsequent visits if required by their insurance companies. Patients are expected to keep their scheduled appointments even though they have enough medications. If you cancel or reschedule your appointment because you have 90 days Rx from previous visit, you will not be given another 90 days Rx in future.
- We appreciate your cooperation in keeping track of your medication supply in order to avoid running out. Refills will normally be handled within 3-5 business days (not including holidays and weekends).
- If you need your medication adjusted or would like to be started on a new medication, we request that you make an appointment with your provider. We will not be able to change the medication / dosage over the phone.
- Our providers require that your keep scheduled appointments as directed, generally every 2-3 months, to keep current as a patient. Your eligibility for prescription refills is determined by keeping scheduled appointments.
- We do not provide refills for medications after hours or on weekends. For your convenience, you may leave a message on our voice mail or with our answering service, but requests are handled during administrative office hours only.
- If a controlled substance / narcotic / stimulant is prescribed to you, it is understood that we are the only provider providing this medication to you. If you obtain this medication (or similar medication) from another provider, without our knowledge, we will no longer provide prescriptions for this medication, and we may be forced to terminate the doctor-patient relationship.
- Prescription refills for ADD/ADHD medications must be sent electronically to the pharmacy. Please make sure you check with your pharmacy if they have the medication in stock before calling our office to request refill to ensure you get your refill in timely manner.

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- Our office does not refill medications for lost or stolen controlled substance prescriptions. If your prescription or medication is lost or stolen and you have difficulty with withdrawal symptoms, you should go to the nearest emergency room.
- **For expired prescriptions for ADD/ADHD medications, a $15.00 fee will be assessed for re-writing the Rx.**

Prior Authorization for medications: Your doctor prescribes medication based on your condition/illness. Sometimes your insurance company limits the availability or free access to certain medications. At times, they may require two copays. These type of restrictions are between you and your insurance company. You need to contact your insurance company if this issue arises. If they require clinical information from the prescribing physician, ask them to fax us a written request. You are required to provide them with your medication history, ID numbers etc**. Please allow us 48-72 hours to get your prior authorization for medication.**

Payment for the services: Payment for the service is due at the time of service. Any past due balance needs to be paid before the next visit. We may need to cancel your appointment if you are unable to pay your balance in full prior to your next visit. We will send two monthly statements and one final collection letter and if the balance is unpaid, it may be turned over to outside collection agency. If you are unable to pay your balance in full, we can offer you a "No interest" payment plan where the minimum payment should be $100 per month and/or balance will have to be paid off in six installments / six months. First payment is due on the day payment plan is set up. Payment on the payment plan statements will be considered separate than you current visit costs which needs to be paid at time of service, regardless of your payments towards payment plan.

Credit Card on file policy: We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $25 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.
Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Other Fees

Medical records, disability forms, work excuses, school notes, calls to employers, return to work letters, etc. will be provided on a fee basis. **The fee must be prepaid in order for us to complete the requested task.** The fee will be based on time spent preparing the requested information.

Medical Records: **There will be a charge of $40.00 for the first 20 pages and $1.00 per page for every copy thereafter** for medical records. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery**. Please note it will take 7-10 business days for processing the records.**

Letters/ Documentation: There is a charge associated with any and all documentation that we may have to complete. The charges will be determined by the amount of time spent to complete the request.

FMLA/Disability Paperwork: We DO NOT do FMLA/Disability paperwork. In rare case, if we fill out FMLA/Disability paperwork, there will be a charge of $40 that you will have to pay. We will not be able to bill your insurance or your employer for that.

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Court Fees: If a deposition or opinion in court is required, there is a $300 per hour charge for the Nurse Practitioner and $500 per hour for the MD to go to court. The minimum charge is $1000 paid in advance. The hourly charge is billed for preparation time, travel time, and any time spent with an attorney/ clerk for preparation. Travel costs (i.e. tolls, gas, and miles) will also be billed to you. Your insurance company will not be billed for any of these fees and you are solely responsible for them.

All fees, including late cancellation and no show fee, are not final and subject to change at any time without notice based on the discretion of the practice.

I have read, understood, and agreed to the policies listed above for Psychiatric Medical Associates. I accept the conditions for receiving service from all the providers of Psychiatric Medical Associates, PA.

_____ _____

Signature Date

_____

Printed Name

Psychiatric Medical Associates, P.A. / NTBHA Affiliate
6404 International Pkwy, # 1010, Plano, TX 75093
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Medication Consent Form

Patient Name : _____ DOB : _____

I have received education regarding the medication that has been prescribed to ☐ me, ☐ my child, or ☐ a person for which I am the legal guardian by and I consent to the administration of this medication. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication. I have also been informed of the reason or intended purpose for which this medication is prescribed. I am aware that the U.S. Food and Drug Administration (FDA) may not have approved this medication to be prescribed for this particular condition or for a patient of this age. I understand this medication education.

- It is recommended that women who are or may become pregnant, or are breastfeeding, discuss this with their practitioner ***before*** taking ***any*** medication and to notify their practitioner ***immediately*** upon becoming pregnant.
- If prescribed benzodiazepines or psychostimulants DO NOT USE with alcohol or operate an automobile/heavy machinery. In addition, DO NOT take within 3 hours of narcotic pain medications.
- If the patient experiences any side effects from the medication prescribed, it is recommended that patient notify their practitioner immediately.
- During the patient's appointment, the practitioner will obtain a thorough patient history. Please let the practitioner know about the following:
  - Current medications (prescription, over-the-counter, herbs, etc.) the patient is taking
  - Food and drug allergies of the patient
  - Any medical conditions of the patient

_____ _____

Patient / Legal Guardian Signature Date

_____ _____

Provider Signature Date

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RULES FOR CONTROLLED PRESCRIPTIONS

Patient Name : _____ DOB : _____

You have elected to start yourself or your child on a medication that is a controlled substance. These medications are frequently used for the treatment of ADHD/ADD. These medications are controlled by the Drug Enforcement Agency (DEA). There are multiple rules and regulations regarding these medications. By signing this document, you are acknowledging and agreeing to follow the rules regarding these and other controlled medications.

1. These prescriptions can ONLY be prescribed during an office appointment. If they are sent electronically to your pharmacy, it may take upto 48 hours for the prescription to be at your pharmacy. You cannot receive this medication outside of an appointment. If there is an extenuating circumstance that does require medication outside of an appointment, there will be a $30.00 fee for the prescription.
2. The prescription expires 21 days from the "earliest fill date". You agree that if you allow a script to expire, or do not pick it up in time, there will be a $15.00 fee to resend the prescription. This courtesy will only be offered **one** time. It is your responsibility to assure you fill your prescriptions on time. You will also only be given enough prescription to hold you until the next appointment.
3. We must see you at least once in maximum of every 90 days in order to prescribe this medication. Please keep scheduled appointments.
4. You agree to not ask any other provider to fill this type of medication while you are being treated by our providers.
5. If controlled medication is lost or stolen, we require that we have a police report on file prior to sending a new prescription. Multiple instances of lost medication may result in disenrollment of patient from the practice.
6. You agree to NOT share or sell this medication to anyone.

I have read, understood, and agreed to the policy listed above for Psychiatric Medical Associates, P.A. / NTBHA.

_____ _____

Signature of patient / legal guardian Date

_____

Name of patient / legal guardian

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Fax # 972-267-3434

By the signature below, I hereby authorize Psychiatric Medical Associates / NTBHA to **release and obtain** information with respect to any **physical, psychiatric, or drug/alcohol related condition** obtained during the course of diagnosis and/or treatment **to/from** individual(s) or healthcare provider(s) below. The type of information authorized includes, but may be limited to, that which is indicated below.

RELEASE TO/OBTAIN FROM By identifying and initialing below you are giving the provider permission **to release and/or obtain psychiatric evaluation, reports of testing, most recent progress notes, treatment plans, medications, and lab reports**.			**INITIAL EACH SPECIFIC CONSENT TO RELEASE**
Family Members or Significant Others	Name/Relationship:		☐ Yes ☐ No Initial _____
	Contact Number:		
	Name/Relationship:		
	Contact Number:		
School RN/School Counselor	Name:		☐ Yes ☐ No Initial _____
	Contact Number/Fax:		
Therapist/Counselor	Name:		☐ Yes ☐ No Initial _____
	Contact Number/Fax:		
PCP	Name:		☐ Yes ☐ No Initial _____
	Contact Number/Fax:		
Employer/HR Department	Name:		☐ Yes ☐ No Initial _____
	Contact Number/Fax:		
Attorney	Name:		☐ Yes ☐ No Initial _____
	Contact Number/Fax:		
Tx Dept of Family and Protective Services CPS	Case Manager Name:		☐ Yes ☐ No Initial _____
	Contact Number/Fax:		
Other	Name/Relationship		☐ Yes ☐ No Initial _____
	Contact Number/Fax:		

I understand that this authorization is voluntary and made at my discretion. I may cancel/revoke this authorization at any time by giving written notice of my desire to do so. **By initialing and signing I have given consent for both verbal and medical records to be released to/obtained from the identified individuals.**

_____ _____ _____
Patient Name Patient Signature Date of Birth

_____
Signature of parent, guardian or authorized representative (if applicable) Date

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CREDIT CARD ON FILE POLICY

At Psychiatric Medical Associates, P.A., we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $25 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.
Your credit card information is kept confidential and secure and payments to your card are processed at the time of service for obtaining any copays, co-insurance or deductibles as per your insurance benefits and after receiving your insurance claim payment / explanation of benefits for any remaining portion which is patient responsibility.

I authorize Psychiatric Medical Associates, P.A. to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number _____

Expiration Date _____ / _____ / _____ CVV # (Security code on back of card) _____

Cardholder Name _____

Billing Address _____

City _____ State_____ Zip _____

Signature _____

I (we), the undersigned, authorize and request Psychiatric Medical Associates, P.A. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Psychiatric Medical Associates, P.A.
This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Psychiatric Medical Associates, P.A. in writing and the account must be in good standing.

Patient Name (Print): _____ Legal Guardian Name (Print):_____

Patient Signature: _____ Legal Guardian Signature: _____

Date: ____/ ____ / _____

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____