



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: \_\_\_\_\_



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



### 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?

Not	Some	More than	Nearly
At all	days	half the	every
		days	day

PLEASE CIRCLE WHICH ONE IF GIVEN 2 CHOICES:

- 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_







## 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 you 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



## 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 rewrite 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 you have a written script that expired, you agree to bring it in to your next appointment. Please do not destroy it. We are required to be accountable for all controlled prescriptions that leave this office.
6. If your script or controlled medication is lost or stolen, we require that we have a police report on file prior to writing a new prescription. Multiple instances of lost medication may result in disenrollment of patient from the practice.
7. 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.

\_\_\_\_\_  
Signature of patient / legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of patient / legal guardian





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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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_



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
<i>Add the score for each column</i>	+	+	+	
Total Score ( <i>add your column scores</i> ) =				

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 \_\_\_\_\_