



Mental Health & Wellness - Austin

**Asad Kirmani, M.D.**  
Psychiatry & Psychotherapy

Date \_\_\_\_\_

### New Patient Information Form

**PATIENT (please print)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

Phone(s): Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Employer \_\_\_\_\_ Job Title \_\_\_\_\_

Full Time/Part Time \_\_\_\_\_ Student \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referred By \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship to You \_\_\_\_\_

Address \_\_\_\_\_

Phone(s): Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

**RESPONSIBLE PARTY (leave blank if self)**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone(s): Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorization below if given on the patient's behalf because the patient is either a minor or unable to sign:

Name (please print) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## New Patient Assessment

### PATIENT (please print)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

**NOTE: *This information is private and confidential.***

In your own words, please describe the problem that you are having.

### MEDICAL HISTORY *Have you ever had any of the following? (please check all that apply)*

- |                                |                          |                       |                          |                             |                          |
|--------------------------------|--------------------------|-----------------------|--------------------------|-----------------------------|--------------------------|
| Chest Pain/Pressure/Tightening | <input type="checkbox"/> | Asthma                | <input type="checkbox"/> | Shortness of Breath         | <input type="checkbox"/> |
| Hypertension                   | <input type="checkbox"/> | Dizzy Spells/Fainting | <input type="checkbox"/> | TB/Lung Disorder            | <input type="checkbox"/> |
| Heart Attack                   | <input type="checkbox"/> | Cancer                | <input type="checkbox"/> | Ulcers                      | <input type="checkbox"/> |
| Stroke                         | <input type="checkbox"/> | Diabetes              | <input type="checkbox"/> | Skin Disorders              | <input type="checkbox"/> |
| Headaches                      | <input type="checkbox"/> | Arthritis             | <input type="checkbox"/> | Hepatitis                   | <input type="checkbox"/> |
| Glaucoma                       | <input type="checkbox"/> | Difficulty Hearing    | <input type="checkbox"/> | Cataracts                   | <input type="checkbox"/> |
| Allergies                      | <input type="checkbox"/> | Memory Loss           | <input type="checkbox"/> | Digestive Problems          | <input type="checkbox"/> |
| Eczema                         | <input type="checkbox"/> | Hemorrhoids           | <input type="checkbox"/> | Frequent Urinary Infections | <input type="checkbox"/> |
| Depression                     | <input type="checkbox"/> | Kidney Disease        | <input type="checkbox"/> | Blood in Stool              | <input type="checkbox"/> |
| Seizures                       | <input type="checkbox"/> | Movement Disorder     | <input type="checkbox"/> | Tics (motor or verbal)      | <input type="checkbox"/> |
| Other Neurological Disorders   | <input type="checkbox"/> | High Cholesterol      | <input type="checkbox"/> | High Triglycerides          | <input type="checkbox"/> |



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## New Patient Assessment (page 2)

### PATIENT (please print)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Have you ever had an injury to your head or other head trauma? Please specify details.

Please list your past surgeries, hospitalizations or other medical problems (including dates).

### ALLERGIES

Are you allergic to any medications? Please specify the medication(s) and your reaction(s).

### CURRENT MEDICATIONS

Psychiatric Medications prescribed by Psychiatrist \_\_\_ Primary Care Provider \_\_\_ Nurse Practitioner \_\_\_ Other \_\_\_

MEDICATION	DOSAGE	PURPOSE	SIDE EFFECTS	HOW LONG?



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### New Patient Assessment (page 3)

**PATIENT (please print)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

**MEDICATIONS (continued)**

Over-the-Counter (please include herbal remedies and include such things as tylenol, advil, etc.)

MEDICATION	DOSAGE	PURPOSE	SIDE EFFECTS	HOW LONG?

**If you are female, please answer the following questions:**

Last menstrual period \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Are you breast feeding? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you using birth control? If so, please specify which type, name and dosage (if pills):

**CHILDHOOD DEVELOPMENT**

**Milestones**

Were motor/walking milestones met at an appropriate age? Yes \_\_\_\_\_ No \_\_\_\_\_

Were vocalizations/talking milestones met at an appropriate age? Yes \_\_\_\_\_ No \_\_\_\_\_



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## **New Patient Assessment (page 4)**

### **PATIENT (please print)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

### **PAST PSYCHIATRIC HISTORY**

Have you ever been admitted to a psychiatric hospital? Yes \_\_\_ No \_\_\_

If yes, please provide dates, length of stay and location.

Are you now participating (or have you ever participated) in psychotherapy or counseling before? Yes \_\_\_ No \_\_\_

If yes, please provide dates, length of therapy and focus of treatment.

Are you currently (or have you ever been) under the care of a psychiatrist? Yes \_\_\_ No \_\_\_

If yes, please provide dates, length of time and focus of treatment.

Have you taken any psychiatric medications in the past? Yes \_\_\_ No \_\_\_

If yes, who prescribed the medication? Psychiatrist \_\_\_ Primary Care Provider \_\_\_ Nurse Practitioner \_\_\_ Other \_\_\_\_\_

If yes, please list the medication(s), dosage(s), length of time, purpose of medication(s), result(s) and any side effect(s).



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## **New Patient Assessment (page 5)**

### **PATIENT (please print)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

### **TRAUMA**

Please describe any traumatic events you have witnessed or experienced.

As a child:

As a teenager:

As an adult:

### **FAMILY STRUCTURE**

With whom did you grow up? Please include family member(s) or others and your relationship to the person(s).

What is your current family living arrangement or family structure? Please include relationship(s) and age(s).

Please list any significant changes in your family or living arrangements that occurred as a child or teenage (such as divorce, death, etc.).



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## New Patient Assessment (page 6)

### PATIENT (please print)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

### DRUG AND ALCOHOL HISTORY

#### Cigarettes/Tobacco

Do you currently smoke or chew? Yes \_\_\_ No \_\_\_

If yes, Number of years \_\_\_\_\_ Number of packs per day \_\_\_\_\_ How long has it been since your last cigarette? \_\_\_\_\_

If you don't currently smoke/chew, have you in the past? Yes \_\_\_ No \_\_\_ When did you quit? \_\_\_\_\_

#### Caffeine

Do you drink coffee or other caffeinated beverages? Yes \_\_\_ No \_\_\_

Number of cups or 8oz servings per day \_\_\_\_\_ Type of beverage \_\_\_\_\_

#### Alcohol

Do you currently drink alcohol or have you within the past year? Yes \_\_\_ No \_\_\_

If yes, how many times per week? \_\_\_\_\_ Type of beverage \_\_\_\_\_ Average number of drinks per week? \_\_\_\_\_

How long have you been drinking? \_\_\_\_\_

If you haven't been drinking in the past year, have you consumed alcohol in the past? Yes \_\_\_ No \_\_\_

Type of beverage \_\_\_\_\_ Average number of drinks per week? \_\_\_\_\_ For how many years? \_\_\_\_\_

When did you stop drinking? \_\_\_\_\_

#### Drug Use

Do you currently use drugs or illicit substances, or have you within the last year? Yes \_\_\_ No \_\_\_

If yes, what type? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_ For how long? \_\_\_\_\_

If you answered no, have you used drugs in the past? Yes \_\_\_ No \_\_\_

What type? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_ For how long? \_\_\_\_\_

How long has it been since you stopped? \_\_\_\_\_

Do you participate in any programs for remaining clean and sober? Yes \_\_\_ No \_\_\_

If yes, what program? \_\_\_\_\_

Are you currently involved in a recovery program? Yes \_\_\_ No \_\_\_

If yes, please describe. \_\_\_\_\_



## New Patient Assessment (page 7)

**PATIENT (please print)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

**FAMILY MEDICAL HISTORY** Please check as applicable to your family history with special attention to anyone with symptoms similar to yours.

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children	Maternal Relative	Paternal Relative
High Blood Pressure										
Epilepsy										
Seizures										
Cancer										
Heart Attack										
Stroke										
Diabetes										
Asthma										
Dizzy Spells/Fainting										
Movement Disorders										
Tics (motor or verbal)										
Other neurological disorders										
Depression										
Bipolar Disorder										
Schizophrenia										
Attention Deficit Hyperactivity Disorder										
Concentration Problems										
Hyperactivity										
Anger Outbursts										
Periods of Severe Agitation										
Nervous Breakdowns										
Anxiety										
Panic Attacks										
Phobias										
Obsessive Thinking/ Worrying										
Compulsions										
Attempted Suicides										
Completed Suicides										
Alcoholism										
Drug Abuse										
Past/present abuse as abuser										
Past/present abuse as victim										
Other (specify)										





Mental Health & Wellness - Austin

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Psychiatry & Psychotherapy

Date \_\_\_\_\_

### Consent for Treatment

I hereby authorize Asad Kirmani, M.D. to bill and collect all payments for medical services rendered to me or my dependent. I consent to treatment of my dependent or me and know that a guarantee of the results of treatment has not been made to me. If Dr. Kirmani determines that a higher level of care is required beyond the scope of this practice (e.g. inpatient or partial hospital program, drug or alcohol rehabilitation, etc), I understand I will be referred to the appropriate setting for continued treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorization below if given on the patient's behalf because the patient is either a minor or unable to sign:

Name (please print) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Patient Record Disclosures

I wish to be contacted in the following manner (please complete only one):

Home Phone \_\_\_\_\_

\_\_\_\_\_ Okay to leave message with detailed information

\_\_\_\_\_ Leave message with call-back number only

Cell Phone \_\_\_\_\_

\_\_\_\_\_ Okay to leave message with detailed information

\_\_\_\_\_ Leave message with call-back number only

Work Phone \_\_\_\_\_

\_\_\_\_\_ Okay to leave message with detailed information

\_\_\_\_\_ Leave message with call-back number only

I have read and understand the above information and agree to these communication terms.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorization below if given on the patient's behalf because the patient is either a minor or unable to sign:

Name (please print) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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### Authorization for Release of Patient Information

I, \_\_\_\_\_ (DOB \_\_\_\_/\_\_\_\_/\_\_\_\_), hereby authorize Asad Kirmani, M.D. and Mental Health and Wellness - Austin to:

- Release information to:
- Obtain information from:

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ FAX \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Information is being shared for the purpose of continuity of care and/or collaboration of care.

**Types of records authorized:**

- All Medical Records
- Psychiatric/Psychological Evaluation and/or Treatment
- Drug/alcohol evaluation and/or treatment
- HIV/AIDS

**Specific information authorized:**

- History and Physical
- Discharge Summary
- Verbal Communication
- Progress Notes
- Psychological Testing
- Lab Tests/Imaging Reports
- Treatment Plan/Summary
- Medication List
- Other \_\_\_\_\_

*This authorization can be canceled at any time by request in writing, but the cancellation will not affect any disclosure already made prior to receipt of cancellation notice. This office cannot control how the protected health information will be used/shared by the agency/person who receives it under this authorization. Unless cancelled or otherwise specified, this authorization will expire one year from date of signature. Other Specified Expiration Date \_\_\_\_\_*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name (please print) \_\_\_\_\_

Authorization below if given on the patient's behalf because the patient is either a minor or unable to sign:

Name (please print) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Professional Services Agreement

*Please read this document carefully. It contains important information regarding patient services and office policies. Dr. Kirmani is happy to discuss with you any questions you may have regarding any of the information contained in this document. Once you sign this document, it will represent an agreement between Mental Health & Wellness - Austin and you.*

### Office Hours , Appointments and Fees

Regular office hours are Monday through Friday except for holidays, and patients are seen by appointment only.

Initial Consultation	60 minutes	\$395
Psychotherapy Appointment	53 minutes	\$250
Medication Management	30 minutes	\$150

To schedule an initial consultation, please call 512.920.3620. Follow up appointments are generally scheduled during your regular visits but may also be requested through the MHW Patient Portal or by calling the office. Please leave a message and your call will be returned by the end of the following business day.

### Appointment Cancellations

Occasionally it may be necessary to cancel or change an appointment, however existing patients must notify MHW at least one full business day (24-hours) in advance of the scheduled appointment. Note that changing a scheduled Monday appointment requires notification on the previous Thursday. Patients are expected to pay for missed appointments unless they have provided the required notification. If you miss three appointments without notification, your services may be discontinued. ***New patients must cancel or change their evaluation appointment at least two full business days (48 hours) in advance of the scheduled appointment or their credit card will be charged for the full amount of the evaluation.***

Patients arriving more than 10 minutes past their scheduled appointment time may be asked to reschedule their appointment and be charged for a missed appointment. Dr. Kirmani will be happy to answer any questions you may have about these policies.

### Medication Policy

Requests for medication refills should be handled during regularly scheduled appointments. Please allow time for your pharmacy to complete your refills and monitor the remaining doses of your medication to anticipate future needs. Lost or stolen medications may not be replaced. Requests for medication refills made outside of regular office visits may result in a \$25 charge.

It is vital that you take all medications as directed by Dr. Kirmani. Skipping doses or abruptly stopping your medication may cause unpleasant or dangerous symptoms. If you take more medication than prescribed, you may not be able to get early refills.



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## **Professional Services Agreement (page 2)**

### **Emergencies/After Hours**

In the event of a true crisis or emergency, call 911 or report to the nearest emergency room or psychiatric hospital. Do not wait until you can get in touch with Dr. Kirmani. Messages left on voicemail are checked several times each business day during normal business hours, but Dr. Kirmani may not be able to reach you right away. Every effort will be made to return phone calls within two business days.

If you are an established patient and you have an urgent issue that cannot wait until the next business day, you may call Medlink at 512.323-5465 to reach the physician on call.

Phone calls longer than five minutes in duration will result in a prorated fee based on the hourly rate of a regular office visit.

Helpful emergency numbers:

Seton Shoal Creek Hospital Administration 512.324.2029

Austin Lakes Hospital Administration 512.544.5253

Travis County Crisis Hotline 512.472.HELP (4357)

National Suicide Prevention Lifeline 1.800.273.8255

Poison Control 1.800.222.1222

### **Confidentiality**

In general, the law protects the privacy of all communication between a patient and a mental health professional.

Information regarding your treatment can only be released with your written permission with the following exceptions:

- In most legal proceedings, you have the right to prevent Dr. Kirmani from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order Dr. Kirmani's testimony if he/she determines that the issues demand it.
- There are some situations in which Dr. Kirmani is legally obligated to take action to protect others from harm, even if he must reveal some information about your treatment. For example, if Dr. Kirmani believes a child, elderly or disabled person is being abused, he must file a report with the appropriate state agency.
- If you threaten to harm yourself or another person, Dr. Kirmani is obligated to seek hospitalization for you and/or inform your family/important others who can help provide protection.

### **Payment Policy**

Payment is due at the time of service by check, cash or credit card. The service charge for a returned check is \$60. If you are having difficulty paying your bill due to some financial hardship, please discuss the situation with Dr. Kirmani to see if there is a mutually agreeable payment plan to allow you to continue treatment.

Seriously delinquent accounts may be referred to a collection agency and may lead to termination of the doctor/patient relationship. Should it become necessary to file suit for unpaid accounts, you will be responsible for any legal charges incurred.



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### Professional Services Agreement (page 3)

#### Insurance

Your insurance policy is a contract between you and your insurance company. Dr. Kirmani is not a party to that contract. Any paperwork that your insurance company requires is your responsibility. Dr. Kirmani will provide you with the necessary information for you to file with your insurance provider. Medical letters, prescription services outside of regular appointments and forms filled out by Dr. Kirmani are all subject to a fee of up to \$75 per 15 minutes.

#### Card Information

MHWA requests that you provide credit card information to be kept on file. Your credit card will be charged for services rendered unless you pay with an alternate method at the time of service. You will be charged for missed appointments, late cancellations, phone calls exceeding five minutes and document preparation.

American Express \_\_\_ VISA \_\_\_ MasterCard \_\_\_  
Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_  
Name on Card \_\_\_\_\_ CID Code \_\_\_\_\_  
Zip Code of Billing Address \_\_\_\_\_

#### Consent to Professional Services Agreement

*Your signature below indicates that you have read and agree with the Professional Services Agreement policies.*

Patient Name (please print) \_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorization below if given on the patient's behalf because the patient is either a minor or unable to sign.

Name (please print) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_



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### **Acknowledgement of Review of Notice of Privacy Policy**

I have reviewed the Notice of Privacy Policy for Mental Health & Wellness - Austin, practice of Asad Kirmani M.D. This document explains how my medical information will used and disclosed. I understand that I am entitled to a copy of this document.

Patient Name (please print) \_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorization below if given on the patient's behalf because the patient is either a minor or unable to sign.

Name (please print) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_