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

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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 Practioner___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 particpating (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 Practioner____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).

Plase 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 MHWA 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 the clinician determines that a higher level of care is required beyond the scope of this practice (e.g. inpatient or partial hospital program, drug or alchohol 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 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
☐ Drug/alcohol evaluation and/or treatment
☐ Psychiatric/Psychological Evalucation and/or Treatment
☐ HIV/AIDS

Specific information authorized:

☐ History and Physical
☐ Progress Notes
☐ Treatment Plan/Summary
☐ Discharge Summary
☐ Psychological Testing
☐ Medication List
☐ Verbal Communication
☐ Lab Tests/Imaging Reports
☐ 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 specificed, this authorization will expire one year from date of signature. Other Specificied 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_____

Mental Health & Wellness - Austin
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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.

		Psychiatrist	Nurse Practitioner
Initial Consultation	60 minutes	$450	$275
Psychotherapy Appointment	53 minutes	$300	$225
Medication Management	25 minutes	$200	$125

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 MHWA 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 MHWA 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. We 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 your clinician. 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.

Mental Health & Wellness - Austin
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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 your clinician. Messages left on voicemail are checked several times each business day during normal business hours, but your clinician 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 of Dr. Kirmani's 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 the clinician from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important important issue, a judge may order the clinician's testimony if he/she determines that the issues demand it.
- -There are some situations in which the clinician is legally obligated to take action to protect others from harm, even if he must reveal some information about your treatment. For example, if the clinician 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, the clinician 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 your clinician 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

Asad Kirmani, M.D.

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, prior authorizations, and forms filled out by the clinician are all subject to a fee of up to $75 per 15 minutes.

Erica Burgett, NP

Erica Burgett accepts insurance assignment from Blue Cross Blue Shield PPO/EPO/High Performance networks (no HMO/no Medicare/no Medicaid). If you are insured by another provider, MHWA can provide you with the necessary information to file your claim with your insurance company. It is your responsibility to understand what your insurance company will cover for the cost of the appointment. Mental Health & Wellness – Austin, PLLC, requires a credit card to be kept on file for copays and any costs not covered by your insurance plan, including but not limited to: eligibility issues or lapse of coverage, phone calls, paperwork, refills requested outside of an appointment, etc.

Clients are responsible for:
1. Confirming mental health benefits with their insurance company.
2. Obtaining any necessary prior authorizations or required referrals for mental health visits.
3. Informing the office of changes to their insurance plan, coverage, or if their insurance is no longer active.

Patients are financially responsible for any amounts not covered by their insurance plan. This includes, but is not limited to copays, deductibles, policy exclusions for mental health, HMO plans, or lapses in insurance coverage. The credit card on file will be automatically charged for any and all of these charges.

Card Information

MHWA requires you to provide a credit card to be kept on file. You will be charged for missed appointments, late cancellations, phone calls exceeding five minutes, and document preparation.

Your credit card will be charged for services rendered as outlined above unless you pay with an alternate method at the time of service.
I
American Express____VISA_____MasterCard____

Card Number_____ Expiration Date _____

Name on Card_____ CID Code _____

Billing Address Zip Code_____

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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.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_____