Afshan Khan, M. D.
4407 Bee Cave Rd
Building 3, Suite 320
Austin, Tx 78746
Phone 512-329-6611
Fax 512-329-6146

Patient Information

Name_____

Current Date_____Age_____DOB_____

Address_____zip code_____

Home Phone_____Cell_____Work_____

Preferred phone to leave a message_____

Referred by_____

Emergency contact name/address/phone number_____

_____

Preferred pharmacy name/address/phone number_____

_____

Guardian name/address/phone number (if applicable)_____

_____

Primary care physician name/address/phone number_____

_____

Please tell us what type(s) of services you are seeking:

_____Therapy _____Medication _____Evaluation

Zaaz Wellness

Afshan Khan, MD, ABPN
4407 Bee Cave Rd, West Lake Hills, TX 78746

Austin Family Institute
512-329-6611

Patient Policies and Procedures

If you have a Medical Emergency, please call 911

MISSED APPOINTMENTS

We are committed to serving our clients and strive to accommodate all clients by making appointments available as soon as possible. When an appointment is reserved for you, we require 48 HOURS NOTICE if you need to cancel your appointment. We understand that emergencies happen, we are happy to work with you in those situations. You will be responsible for a missed appointment fee of $50 if your unable to keep the scheduled appointment and do not notify the office 48 hours in advance. This fee is due and payable before your next appointment and is not filed with insurance, as it is a non-covered service.

If a patient does not show up for two (2) consecutive appointments, without notifying the office, it is assumed that the doctor-patient relationship has been terminated and must be re-established for further treatment (medication, therapy, etc.) to continue.

INSURANCE

We participate with some insurance plans. We do not file claims to any insurance in which we do not participate. Each insurance plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is ultimately your responsibility to check with your insurance company to determine covered benefits. PLEASE REMEMBER: The agreement of the insurance carrier to pay for health care is a contract between you and the insurance company. Any questions or complaints regarding coverage should be directed to your insurance company.

AFTER HOURS PHONE CALLS

There will be a minimum $20 fee for NON-EMERGENT after-hours phone calls that last more than five (5) minutes that are therapy related. The physician on call will decide as to whether the situation is an emergency and whether a fee should be charged. This fee is the patient/guarantor's responsibility and is NOT billed to insurance.

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PRESCRIPTION REFILLS

It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three to five business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

Medication refills will only be addressed during regular office hours (Monday-Friday 8am-5pm). The urgent care staff will not return any phone calls regarding refills. Please 1notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.

Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guaranty that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 4 to 6 weeks.

If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact us immediately. New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

Stimulant medications for ADD/ADHD are controlled substances and refills cannot be called into a pharmacy, per state law and regulations. Rather, a paper prescription form must be submitted to the pharmacy for a stimulant medication to be filled.

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FMLA AND DISABILITY POLICIES

The goal of treatment at Zaaz Wellness is to foster full recovery to optimal level of functioning. Studies have consistently shown that employment can provide an enhanced sense of well-being. Generally speaking, it is the philosophy of this clinic that employment provides structure and routine, which are necessary components of mental wellness. Recommendations by this clinic will typically include commitment to regular therapy sessions, which can include vocational rehabilitation services for those seeking disability. The expectation is that all parties will be fully engaged in all aspects of treatment to facilitate maximum therapeutic benefit and return to full functioning.

FMLA AND DISABILITY POLICIES (Cont'd)

This office utilizes a standardized FMLA form that contains the federally required components of information necessary for FMLA eligibility determination. Completion of paperwork related to FMLA or disability is at the discretion of the provider. A $100 fee must be collected in advance of completion of FMLA or disability forms. Zaaz Wellness does not guarantee that FMLA or disability will be granted based upon records submitted and cannot be held responsible for determinations made.

I hereby authorize payment of insurance benefits to be made to ZAAZ. I further understand that if my insurance company denies any or all medical services as "non-covered", "coverage terminated", "pre-existing" or "not a covered member", I will be responsible for full payment within 30 days of said denial(s), or within 30 days of the first billing statement sent by ZAAZ following the receipt of said denial(s). I understand that ZAAZ will not file any claims for non-covered services. I further understand that ZAAZ does NOT file supplemental, secondary or tertiary claims EXCEPT for the following: 1) Medigap (Medicare supplement) coverages in which ZAAZ participates, OR 2) where ZAAZ participates with BOTH the primary and secondary coverages. I understand that I will be legally responsible for all collection costs associated with the collection of this account including court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on any unpaid balance.

I fully understand the above policies and agree to be financially responsible for all incurred charges for this account.

_____ _____

Client Signature Date

NOTICE OF PRIVACY PRACTICES AND POLICIES

EFFECTIVE 7/1/2015 AS REQUIRED BY FEDERAL LEGISLATION, THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This notice applies to all of the paper and electronic records of your care maintained by Afshan Khan, M.D. whether created by myself, my personnel, or records acquired from outside resources such as other clinicians involved in your care and laboratory reports.

WAYS THE PRACTICE MAY USE AND DISCLOSE YOUR INFORMATION:

The following categories describe ways that I use and share your confidential information. Confidential information includes Protected Health Information (PHI) (information that could be used to identify you). Not every use or disclosure in a category is listed. However, all of the ways I am permitted to use and disclose information will fall within one of the following categories.

A. DISCLOSURES WHICH REQUIRE AUTHORIZATION

Psychotherapy notes are handled separately under HIPAA and have additional protections. Specifically, the regulations state that in most instances a practice must obtain an authorization for any use or disclosure of psychotherapy notes. No authorization is needed to carry out treatment, payment, healthcare operations, or the uses listed in routine situations. All other circumstances require a valid authorization from you for use and disclosure. Confidential information may be released for payment and healthcare operations only to health insurance plans and their agents, as well as business associates of the practice. The definition of a health insurance plan does not include life insurance companies, automobile insurance companies, or workers' compensation carriers. These are not covered under HIPAA. If you would like information submitted to one of these companies, an authorization will be required, unless it is already mandated by state or federal law.

B. ROUTINE SITUATIONS

- For Treatment I may use information about you in order to provide you with proper medical treatment or services. Treatment is when I provide, coordinate, or manage your healthcare and other services related to your healthcare. An example of treatment is when I consult with another healthcare provider, such as your primary care physician.
- For Payment I may use and disclose information about you so that the treatment and services you receive may be billed and payment can be collected from you, an insurance company, or a third party (including a collection agency if necessary). For example, I may give your health insurance plan information about services you received at the practice, so your health insurance can pay my practice or reimburse you for the services. I may also tell your health insurance plan about a treatment you are going to receive, in order to obtain prior approval or determine if your plan will cover the treatment.
- For Healthcare Operations I may use and share information about you for administrative functions necessary to run my practice and promote quality care. I may share information with business associates who provide services necessary to run my practice, such as transcription companies or billing services. I will contractually bind these third parties to protect your information as I would. Also, I may
- permit your health insurance plan or other providers to review records that contain information about you to assist them in improving the quality of service provided to you.
- Communicating with You and Others Involved in Your Care My practice may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. In certain situations, I may share information about you with a friend or family member who is involved in your care or payment for your care unless you have requested that such disclosures not occur and I have agreed. Information disclosed will be directly relevant to such person's involvement with your care or payment related to your care. Whenever possible, this person will be identified by you. However, in emergencies or other situations in which you are unable to indicate your preference, I may need to share information about you with other individuals or organizations to coordinate your care or notify your family.

C. SPECIAL SITUATIONS

- As Required By Law: I will disclose information about you when required to do so by federal, state or local law. For example, I may release information about you in response to a valid court subpoena.
- Health Oversight Activities: I may disclose information to a health oversight agency for activities authorized by law. For example, these oversight activities include: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
- For Judicial or Administrative Proceedings: If you are involved in a court proceeding, and a request is made for information about the professional services that you have received within my practice and the records thereof, such information may be privileged under state law. I will not release information without the written authorization of you or your legal representative, or in instance of issuance. This may also be the case in the instance of a court subpoena, which requires the provision of such information, which you have been properly notified. In response, you have not opposed the court subpoena within the legally specified format and timeframe, or in the instance of the issuance of a court order compelling me to provide Protected Health Information (PHI). This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- To Avert Serious Threat to Health or Safety: I may disclose your confidential mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual. These disclosures may be to law enforcement officials to respond to a violent crime or to protect the target of a violent crime. For example, threats of harming another individual may be reported to appropriate authorities.
- Worker's Compensation: If you file a worker's compensation claim with certain exceptions, I must make available at any stage of the proceedings, all PHI information in our possession that is relevant to that particular injury in the opinion of the Texas Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

- Public Health Risks: I may disclose information about you for public health activities. These activities generally include, but are not limited to, the following:
  - To prevent or control disease, injury, or disability
  - To report child abuse or neglect
  - To report adult and domestic abuse
  - To report reactions to medications or problems with products
  - To notify people of recalls of products they may be using
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
  - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.
- Law Enforcement: I may release information about you if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons, or similar process
  - To identify or locate a suspect, fugitive, material witness, or missing person
  - If you are suspected to be a victim of a crime, generally with your permission
  - About a death we believe may be the result of criminal conduct
  - About criminal conduct at the hospital
  - In emergency circumstances involving a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

YOUR RIGHTS AS A PATIENT

In addition to provisions by the practice to protect your confidential information, you are entitled to six (6) specific rights as a patient.

- You have the right to request restrictions on certain uses and disclosures. You have the right to request a restriction or limitation on the use and sharing of information about you for treatment, payment, administrative functions, or with individuals involved in your care. To request restrictions, you must make your request in writing to me. In your request, you must tell me:
  - what information you want to limit;
  - whether you want to limit use, disclosure, or both; and
  - to whom you want it to apply.

  I am not required to agree to your request. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.
- You have the right to receive confidential communications. You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a post office box. To request confidential communications, you must make your request in writing to me. Your request must specify how or where you wish to be contacted. I will not ask you for the reason and will seek to accommodate all reasonable requests.
- You have the right to inspect and obtain copies. You have the right to review and obtain copies of information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information compiled in reasonable anticipation of a legal action or proceeding; and confidential information related to certain laboratory tests under Clinical Laboratory Improvement Amendments (CLIA). To inspect and copy information that may be used to make decisions about you, you must submit your request to me in writing. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request. In the following circumstances I may deny your request to inspect and copy information:
  - I have determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of you or another person;
  - The information makes reference to another person (unless the other person is a healthcare provider) and I have determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to the other person
  - The request for access is made by your representative and I have determined, in the exercise of professional judgment, that the provision of access to your personal representative is reasonably likely to cause substantial harm to you or another person. If you are denied access, you may request a review of the denial by another licensed medical practitioner. I will comply with the outcome of the review. If your request only concerns billing information, you may call my office at 512-329-6611.
- You have the right to amend confidential information. If you feel that the information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for my practice. To request an amendment, your request and a reason that supports your request, must be made in writing and submitted to me. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that:
  - Was not created by my practice, unless the person or entity that created the information is no longer available to make the amendment. In such instances I would consider the request
  - Is not part of the information kept by or for my practice
  - Is not part of the information which you would be permitted to inspect and copy
  - Is accurate and complete
- You have the right to receive an accounting of disclosures of confidential information. You may ask to receive an accounting of certain disclosures made about you that were not related to the routine uses listed above. To request this list or accounting of disclosures, you must submit your request in writing to me. Your request must state a time period that may not be longer than six (6) years and indicate what format you want the list (for example on paper or in an electronic file). The first list you request

will be free. For additional lists, I may charge you the cost of providing the list. I will notify you of the estimated cost involved and you may choose to withdraw or modify your requests because any costs are incurred. Disclosures do not have to be made when those disclosures are:

- To carry out treatment, payment and healthcare operations
- To individuals of confidential information about them
- As a result of assigned authorization
- For the practice's directory or to persons involved in your care
- For national security or intelligence purposes; or
- To correctional institutions or law enforcement officials
- You have the right to obtain a paper copy of this Notice upon request. Even if you have requested an electronic copy, I will provide you with a paper copy of this Notice at your request.

MY PRACTICE'S DUTIES

In addition to your rights as a patient, my practice has duties to protect your confidential information and inform you of changes to protection measures. I am required by law to maintain the privacy of confidential information and provide you with notice of my legal duties and privacy practices with respect to such information. I am required to abide by the terms of this Notice currently in effect.

CHANGES TO THIS NOTICE

I reserve the right to revise or change provisions on this Notice. I will make the new Notice provisions effective for all confidential information I maintain. I will promptly revise and distribute my Notice whenever there is a change to the uses or disclosures, your rights, and my duties, or other privacy practices stated in this Notice. I will mail updates of my notice to all active patients. Patients who are inactive at the time of mailing may receive an updated copy at their next scheduled appointment. A copy of the current Notice will be available throughout my practice. The Notice will contain the effective date on the top of first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted or verified in writing. You have specific rights under the Privacy Rule. You will not be penalized for filing a complaint.

OTHER USES OF INFORMATION

Other uses and disclosures of information not covered by this notice or the laws that apply to my practice will be made only with your written permission. If you provide my practice with specific permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that have already been made with your permission and that I am required to retain our records of the care that we provided to you.

PRIVACYOFFICER

I am the privacy officer for my practice. You may contact me with questions or comments by telephone at (512) 329-6611, or by mail to: Afshan Khan, M.D. 4407 Bee Cave Rd, Bldg 3, Suite 320Austin, TX 78746

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I am required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving this Notice. You may contact me with questions or comments by telephone at (512) 329-6611, or by mail at: Afshan Khan, M.D. 4407 Bee Cave Rd, Bldg 3, Suite 320, Austin, TX 78746

PLEASE SIGN AND BRING THE FOLLOWING 3 PAGES TO YOUR INITIAL CONSULTATION.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND POLICIES

In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

I have received a copy of the Notice of Privacy Practices and Policies from: Afshan Khan, M.D. 4407 Bee Cave Rd, Bldg 3, Suite 320 Austin, TX 78746

Patient Signature: _____ Date: _____

Printed Name: _____

Authorization below is 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: _____

AFSHAN KHAN, M.D.
4407 BEE CAVE ROAD, BLDG. 3, STE. 320, AUSTIN, TX 78746
(512) 329-6611 (p)
(512) 329-6146 (f)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE POLICIES AND PROCEDURES

I have received a copy of Afshan Khan, M.D.'s Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy.

Patient Signature: _____

Date: _____

Authorization below is 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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CONSENT FOR TREATMENT

I, the patient or patient's legal representative, hereby grant permission to Afshan Khan, M.D. to perform such examinations, medical, and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations.

I am aware that the practice of medicine is not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination.

Patient Signature: _____

Date: _____

Authorization below is 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: _____