



Beautiful Minds
Dr. Humera Chowdhary MD

Beautiful Minds for Beautiful Lives

Humara Chowdhary MD
Medical Director

8501 Wade Blvd, Suite 110
Frisco, TX 75034
972-668-3109 Phone
972-668-3110 Fax

Therapist: _____

Patient: _____

Date: _____

Welcome to Beautiful Minds

Thank you for choosing, us as your psychiatrist at this point in your personal journey. It is a difficult decision to share one's innermost thoughts, feelings, and burdens with a professional. We hope we can work together successfully for your and /or your child's ongoing personal growth and development.

Our foremost goal is patient care. Feel free to ask any questions regarding your treatment or progress, and please let us know if there is a better way to assist you.

Please complete the following pages in this intake packet. We will be glad to discuss any questions you have regarding these forms and will provide you a copy of these forms upon request.

Beautiful Minds strives to use an integrated team approach to treatment. Our practitioners typically focus on comprehensive psychiatric treatment. We may encourage, educate, direct, or provide psychological and social support recommendations or interventions as appropriate and individualized for each person provided care. Dr. Humera Chowdhary, and has specialized training in Psychiatry in addition to meaningful clinical experience and wisdom.

Of course, if you are ever unable to reach us in an emergent situation, you are advised to seek appropriate emergent care or call 911.

Thank you in advance for taking care and making note of these important administrative details contained in this packet.

Best Regards,

Dr. Humera A. Chowdhary, MD

Beautiful Minds, 8501 Wade Blvd, Suite 110, Frisco, Texas 75034

Prior to your first appointment please complete:

- 1) Registration form/Directive handling Appointments and Billing
- 2) HIPAA form
- 3) Authorization to Release of Protected Health Information
- 4) Medical History form
- 5) Office Policy form

All forms are located in the “Forms” section of this website for you to download and complete.

Bring with you to the first appointment:

- 1) All medications you are currently taking
- 2) Any medical records that might be useful in your evaluation- labs, recent physical, IQ or psychological testing results, in addition for children also recent report card, behavior sheets.
- 3) Ensure your new patient paperwork has been completed ---make sure you have read and signed all forms.
- 4) For minors, if parents are divorced or child is in another’s custody the legal guardian **must** bring custody papers otherwise the child will not be evaluated.
- 5) Support person-spouse, significant other, parent, legal guardian, etc.
- 6) A form of payment (cash, check, or credit card)

Please arrive at least 30 minutes early to complete registration and check in to maximize your scheduled appointment time.

Patient Registration – Please insure this form is fully completed.

Date: _____

Patient Information

Last Name	First	Initial
Address		
City	State	Zip
Home phone	Work phone	
Cell phone	Alternate phone	

Do you give office staff permission to leave phone messages: Yes _____ No _____

Social Security Number: _____ - _____ - _____ DOB _____ - _____ - _____ Age: _____

Marital Status: Single Married Divorced Widowed

Race/Ethnicity: African American Asian Caucasian Hispanic Other _____ Employed:

Yes No Sex: Male Female Student: Yes No

Employer Address		
City	State	Zip
Work Phone		
Spouse's Name	Spouse's DOB _____ - _____ - _____	
Spouse's Work #	Spouse's SSN _____ - _____ - _____	

Emergency Contact: _____ Phone # _____

Relationship to Patient: _____

Preferred Pharmacy and location/phone number _____

Referral Source: _____ Specialty: _____

Referral Phone # _____

By providing phone numbers, consent is granted for reasonable communication by these numbers, including voice mail. I agree to keep the office updated regarding changes to this information.

Is Patient a Minor? Yes No If Yes, then a parent/guardian must complete

Parent Name	Parent DOB: _____ - _____ - _____	
Address	Parent SSN: _____ - _____ - _____	
City	State	Zip
Home phone	Work phone	
Relationship to Patient	Employer	

Signature of Patient/Parent/Guardian

Date

Assignment of Insurance Benefits for Payment from Your Insurance Carrier/Provider

Insurance Carrier/Provider Name: _____

ID #: _____

Group #: _____

Effective Date: _____

Insured Party (if other than patient)

Name: _____

Date of Birth: ____/____/____

Address: _____

SSN#: _____

Relationship to Patient: _____

Consent to Release Claims Information/Assignment of Benefits

I hereby assign, transfer and set over all right, title and interest to my medical reimbursement benefits under my insurance policy with the above insurance company.

I hereby consent for Beautiful Minds or any of its employees or agents to release and disclose any information required about me (or the above named patient) to my insurance carrier, claims administrator, managed care company, or review agency and their employees or agents for the purpose of treatment, healthcare operations, and evaluation of claims for payment.

I understand insurance billing is a service provided as a courtesy, and I am at all times personally responsible for any fees not covered by insurance. Should any insurance payment be made directly to me or I agree to immediately forward those funds to Beautiful Minds. I also acknowledge I am responsible for any deductible, co-pay, or any other balance not covered by my insurance carrier/provider.

Patient/Guardian Signature: _____ **Date:** _____

Guarantor's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient-Provider Partnership Agreement

Prescriptions and Refills

Refills are routinely handled by fax or electronic transmission. When you have seven days of medication left, please contact your pharmacy and have them contact Beautiful Minds for a refill. Please allow 3 - 5 business days, after you have contacted your pharmacy, for all refill requests.

If you are not current with your appointments, refill requests may be denied.

Termination of Physician – Patient Relationship

- The patient will only be considered an active patient of this practice if the patient keeps each appointment or makes alternative appointments with this office.
- After the passage of four months without contact between the practitioner and the patient, the patient may be considered an inactive patient.
- Inactive status designates that the practitioner will reserve the right to direct triage to another provider or facility if the need arises. Only emergency triage will be provided. If medication has been prescribed continuously by the practitioner and inactive status occurs, a maximum of one month of medication may be prescribed while the patient finds an alternative healthcare provider.
- Inactive status may be instituted after two appointments missed with less than 24 hour cancellation notice.
- **The following are some of the situations that would make this necessary:**
 - * After the third missed appointment
 - * Non-payment of account
 - * Not following treatment recommendations
 - * Misuse / abuse of prescribed medications
 - * Abusive behavior towards office staff

Conditions for Treatment

By signing below you are acknowledging that you:

- a) Will keep scheduled appointments
- b) Complete all recommended courses of therapy and treatment
- c) Obtain all tests ordered by the practice
- d) Schedule specialty referrals as advised
- e) Promptly notify the physician if there are significant changes in your condition
- f) Acknowledge that failure to follow the “**Conditions of Treatment**” may result in termination from the practice.

Complaints You May Have with Your Insurance

The Beautiful Minds is a private pay clinic. Insurance benefit appeals and grievances are handled between you and your insurance company or their designee.

You may discuss complaints directly with your practitioner at any time regarding your care or clinic billing issues.

You have the right to request an appeal in the case that visits are denied certification with your insurance company or their designee. You risk nothing in exercising this right. The Texas Department of Insurance is responsible for regulating healthcare services. You may contact Texas Department of Insurance at (800) 252-3439 or www.tdi.state.tx.us

Patient-Provider Partnership Agreement

Financial Agreements

Our fees are as follows:

	<u>Usual & Customary</u>
Initial Psychiatric Diagnostic Evaluation	\$350
Ongoing Care Visit, 15-20 minutes, low complexity	\$140
Ongoing Care Visit, 17–20 minutes, medium complexity	\$140
Ongoing Care Visit, 20-30 minutes	\$180
Ongoing Care Visit, 35-45 minutes	\$270
Ongoing Care Visit, 60 minutes	\$350
All Other Services, \$350/hour, prorated in 10 minutes increments	\$350/hour
Late Cancellation, less than 24-hour or one business day notice	\$35
Missed Appointment Fee	\$35
Check Returned for Insufficient Funds	\$45
Controlled Schedule II Prescriptions requested between appointments	\$20
Contacting NP after hours for Emergency Medication Needs	\$45

Court Fees: If a deposition or opinion in court is required, there is a \$360 per hour charge. The minimum charge is \$1,080 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 will also be billed from door-to-door.

Medical Records: \$25 for the first twenty pages and \$.75 per page for every copy thereafter, or \$30 per CD copy provided. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery. If an affidavit is requested, certifying that the information is a true and correct copy of the records, an additional fee of \$30 will be charged for executing the affidavit.

Letters/Documentation: The charge will be determined by the amount of time spent to complete the request.

Phone Calls to Practitioners: During business hours please call our office staff for any questions. As I am with patients, I do not check my messages till the end of the business day. My staff can inform me of any urgent issues in a timely manner if you contact them directly.

Appointments

Initial appointments will generally last 60 minutes. Follow-up appointments are usually 20 or 45 minutes.

Patients who arrive more than 15 minutes after their scheduled appointment time, will not be seen. They will be rescheduled (and assessed the \$35 missed appointment fee) so that other patients can be seen on a timely basis. Payment is expected in full at the time of service, or you will be asked to reschedule when payment can be made. Missed appointment fees are not covered by your insurance, and charges associated with them are solely your responsibility.

If you are using your insurance benefits, you agree to assign payment from your health plan to Beautiful Minds. It is your duty to notify this office if you have a change in insurance coverage. You are responsible for obtaining prior authorization/certification for treatment from your insurance company or their designated organization. Failure to do so may result in you being billed for that appointment. **We will bill your insurance company if we are a contracted provider; however, you are responsible for co-payments, deductibles, and payment for services not covered by your health plan.** If you have a deductible, you must pay for your visits until the deductible has been met. These payments are payable at each appointment.

Cancellation and Missed Appointment Policy

Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with fewer than 24 hour notice, you will be responsible for the fee. Repeated “no-show” appointments could result in you being referred out of the clinic to another practitioner. Your insurance company will not be billed for fees associated with cancelled or missed appointments, the patient will be solely responsible for payment of their fees. Monday appointments require notification before 12 p.m. the preceding Friday.

Patient-Provider Partnership Agreement

- I will be honest and report progress (or lack thereof), side effects, or any dangerous thoughts immediately when the session begins.
- I will follow all recommendations regarding medications and, particularly, regarding protections for safety.
- I will be responsible for keeping my medications in a safe place and I or my child will take the medications as prescribed.
- I will inform Beautiful Minds of all hospitalizations (including Intensive Outpatient Treatment and Partial Hospitalization Programs) of psychiatric nature.

- I understand my provider may call 911 if necessary to protect safety. This may occur without discussion if the patient does not immediately present a plan for safety when deemed clinically reasonable by the provider.
- I understand my prescription may not last between appointment intervals. I understand I need to contact my pharmacy to have a refill fax request sent to Beautiful Minds when I have seven days of medication left.
- I understand that if Controlled Schedule II Prescriptions are requested between appointments a \$20.00 fee will be assessed.
- I understand that the office hours are (Monday-Thursday 8-5), (Friday 8-12). In case of an after- hours emergency, I should go to the nearest Emergency room or call 911.
- I understand there is a non-wavering protocol for disability services. I also understand all fees associated with paperwork and calls to the disability carrier are not insurance reimbursable and must be paid before the paperwork will be completed.
- I understand all fees are expected to be paid at the date and time services are rendered. Nonpayment may result in a referral to another provider.
- I understand in an effort to focus treatment and provider results, my practitioner(s) will evaluate progress on an ongoing basis. If improvement is not significant as would be expected for your condition, the practitioner may refer you to a new clinic. Our practitioners do not believe it is ethical to continue treatment with no clear results and restoration to previous functioning or reasonable maintenance of clinical status. New “eyes” may be needed in these circumstances.
- I understand submitting preliminary healthcare or insurance information or making an appointment with the practice does **not** establish a physician-patient relationship.

THE FIRST APPOINTMENT IS ON A CONSULTATION BASIS ONLY until we have met and formulated a “treatment contract”.

Patient/Guardian Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Fee Items which are YOUR responsibility and are not covered by insurance

When you cancel an appointment with less than 24 business hours you will be assessed a late cancel fee of \$35.00. When you do not show up for an appointment, or arrive 15 minutes (or later) after your scheduled appointment time, you will not be seen and you will be assessed the \$35.00 missed appointment fee.

Controlled Prescription Policies

CII prescriptions are highly controlled and followed by the State of Texas. **Due to administrative requirements placed on our clinic, it is now necessary for us to implement a \$20.00 fee on CII prescriptions for those requested between office visits** (this is for medications such as Adderall, Concerta, Daytrana, Focalin, Quillivant, Ritalin and Vyvanse etc.)

If you request a prescription during a regular office visit, there will be no fee assessed to you. If you fail to have the medication filled within the required 21 day period, if you lose the prescription, or if you need a refill and do not have a set appointment (you must be approved by the clinician to pick up meds in between appointments), the \$20.00 fee will be assessed to you. **The prescription WILL NOT be given to you until the fee is paid.**

Guidelines regarding prescriptions, refills, and emergency medication refills after hours

For each patient current and future, we would like to clarify our medication refill guidelines and practices. It is our belief, in general, refills are handled best at the time of your face-to-face visit with your practitioner. **Please review and be ready with your medication refill requests at the time of your face-to-face visits.**

All other refills not handled during your face-to-face visit will be handled by fax when appropriate (with the exception of controlled prescription policies specifically covered below). **When you have 1 week remaining on a prescription, contact your pharmacy and request a prescription refill.** They will fax a refill request to our office. Please allow 3 to 5 business days for all refill requests, once you have contacted your pharmacy. **If you are not current with your face-to-face appointments, your refill request may be denied.**

If the above is not possible, the patient can visit a local emergency room or emergent care clinic for an emergency supply of medication.

After 4pm during business hours, medications will be refilled within 24 business hours.

If you have any questions or concerns, please feel free to address those with the provider. Thank you for your attention to this matter. I have had an opportunity to read and discuss this with office staff.

Patient/Guardian Printed

Signature

Date

Office Witness printed name

Office Witness Signature

Date

Consent for Treatment

I hereby authorize and give my voluntary consent to receive evaluation, consultation, and/or medications or treatment in the care of Dr. Humera Chowdhary at Beautiful Minds or appropriate designate as considered necessary and advisable by the practitioner.

I understand I will be encouraged to participate actively in the formulation of a plan for my treatment. If I have any questions or concerns about this treatment plan, I may discuss these with the practitioner.

I understand the explanation about the services I will receive, and I agree to comply with the agreed upon evaluation or treatment strategies. I understand if any change in the treatment program is to be made, an explanation of the change will be given to me, and my consent for the change will be obtained before the treatment program change is made. I can expect to be advised of the benefits and risks of any treatments prescribed for me.

I acknowledge no guarantees have been made to me as to the result of this treatment.

I understand I may terminate my treatment from Beautiful Minds at any time.

If I am seeking evaluation, treatment, and/or care for a child, I acknowledge I have legal authority to seek and obtain voluntary outpatient psychiatric health services for this child.

Patient/Guardian Printed Name

Date

Patient/Guardian Signature

Date

Witness Signature (For office use only)

Date

This form allows the exchange of information between Beautiful Minds and the person(s) to whom you grant consent below, especially your primary care physician and/or therapist. The goal of such information exchange is to coordinate your care as best as possible. The information exchanged may include psychiatric evaluation, treatment, medical, laboratory, and/or therapy information.

If the patient is 18 years or older and/or on their parent's insurance, it is advised to include parent's name and phone numbers on this consent form.

Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

Legal Guardian Signature Required if patient is under the age of 18

Patient's Primary Care Physician:

Name: _____

Address: _____

Phone: _____

I authorize the release of information to Beautiful Minds and for Beautiful Minds to release information to my (or my child's) primary care physician. This includes verbal communication between these persons or agencies.

Signature: _____

Patient's Therapist:

Name: _____

Address: _____

Phone: _____

I authorize the release of information to Beautiful Minds and for Beautiful Minds to release information to my (or my child's) therapist. This includes verbal communication between these persons or agencies.

Signature: _____

Patient's _____: Relationship _____

Name: _____

Address: _____

Phone: _____

I authorize the release of information to Beautiful Minds and for Beautiful Minds to release information to my (or my child's) _____. This includes verbal communication between these persons or agencies.

Signature: _____

Patient's _____: Relationship _____

Name: _____

Address: _____

Phone: _____

I authorize the release of information to Beautiful Minds and for Beautiful Minds to release information to my (or my child's) _____. This includes verbal communication between these persons or agencies.

Signature: _____

This above release is subject to revocation by the above signed at any time except to the extent that action has already been taken. Revocation must be submitted in writing. Beautiful Minds is not responsible for confidential information which is passed on to any party not named in this release.

HIPAA

Acknowledgement of Review of Notice of Privacy Practices for Beautiful Minds, Dr. Humera Chowdhary, M.D.

I have reviewed Beautiful Minds Notice of Privacy Practices which explains how patient medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I request it.

Print Patient Name

Signature of Patient or Guardian

Relationship

Date

Witness Signature (For office use only)

