Welcome to Beautiful Minds

BEAUTIFUL MINDS/ NORTH TEXAS PSYCHIATRIC ASSOCIATES, PA
Humera Chowdhary, MD
8501 Wade Blvd, Ste 110
Frisco, TX 75034
Ph: 972-668-3109 Fax: 972-668-3110 www.Beautifulmindstx.com

Registration Packet

Thank you for choosing Beautiful Minds 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 you and/or your child's ongoing personal growth and development.

Our foremost goal is providing the best patient care. Feel free to ask any questions regarding your treatment or progress, and please let us know if there is a better way we can 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 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 whom we provide care.

Dr. Humera Chowdhary and her staff have specialized training in Child, Adolescent and Adult Psychiatry, in addition to meaningful clinical experience and wisdom.

Of course, if you are ever unable to reach us in an emergency 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,
Humera A. Chowdhary, MD

Prior to your first appointment please complete:

1) Registration form
2) HIPAA form
3) Authorization to Release of Protected Health Information
4) Medical History form (Patient Intake)
5) Office Policy form

All forms are located in the "Forms" section of this website for you to download and complete or complete the Registration packet online from the forms drop down menu at:
(www.beautifulmindstx.com)

Bring with you to the first appointment:

1) All medications in their bottles that you are currently taking
2) Any medical records that might be useful in your evaluation- (ie. previous records, labs, recent physical, IQ or psychological testing results, and for children their 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 or credit card)

Please arrive to your in office appointment at least 20 minutes early to complete registration and check in to maximize your scheduled appointment time.

Patient Registration - Please ensure this form is fully completed.

Disclaimer: Please read all details of this form so that you aware of all policies and we can provide you with the best quality of care.

Patient Name	
Address	
Cell phone number	
Do you give office staff permission to leave voice messages?	
Patient DOB	
Patient's Age	
Emergency Contact Name	
Emergency Contact phone number	
Relationship to patient	
Preferred Pharmacy/Location/Phone#	

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

	Date:

Patient/ Parent/ Guardian Signature

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

Insurance Carrier/Provider Name	
Member ID #	
Group #	
Address of Insured party	
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. My agreement for insurance coverage is between me and my insurance company, **NOT** with this office. Should any insurance payment be made directly to me, 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.

	Date:

Patient/ Parent/ Guardian Signature

Complaints You May Have with Your Insurance

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

Appointments

Initial appointments will generally last up to 60 minutes. Follow-up appointments are usually 20-45 minutes. **Patients who arrive more than 15 minutes after their scheduled appointment time will not be seen.** They will be rescheduled (and assessed the $50 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 $50 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. Cancelling Monday appointments require notification before 5 p.m. the preceding Thursday.

Patient-Provider Partnership Agreement

As a patient I agree ...

*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 my 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 the office hours are (Monday-Thursday 9-5). 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."

	Date:

Patient/Parent/Guardian Signature

<u>Conditions of Treatment</u>

By signing below you are acknowledging that you agree:

For my appointments:

- I understand the reminder calls and reminder texts are **only a courtesy**, and I must keep track of my own appointment day and time.
- I understand that I must provide a **quiet and private environment** with a secure internet connection to complete my televisit appointments. (Please no **driving, distractions or shopping. No public places or group settings**).
- I will keep my scheduled appointments. I understand that each patient is required to **provide 24 hours notice** if I need to cancel an appointment or a **$50 fee** will be added to my account as a personal responsibility charge for a same-day cancellation or a no show fee.
- I understand that each patient is **required to complete a check-in sheet and/or rating scales for EVERY appointment** as they are now requested by some insurance companies as proof of visit.
- I understand I will bring my current medication bottles to **EVERY** appointment to verify doses and dates **BEFORE** my tele-visit starts.
- I understand that I will complete all recommended courses of therapy and treatment and schedule specialty referrals as advised by my provider.
- I understand that I must complete or obtain all requested documents and/or lab order requests from the office.

Standard Office Rules:

- I understand that when I have **5** days of meds left, I will send a klara message requesting additional medications. I **will not wait** until I am completely out of medication before reaching out to the office. AND I understand that if I am **not current** with my appointments, my refill request may be denied.
- I understand that my provider is seeing patients throughout the day and may not be able to answer my questions until the **end of their day**.
- I understand that if any of my controlled medication is lost, misplaced, destroyed or stolen, I must file a **local police report** and provide a copy of it to my provider for review to determine <u>**if**</u> an additional refill will be sent.
- I understand that **I am responsible** for ensuring that I have enough medication until my next scheduled appointment.
- I will complete all recommended courses of therapy and treatment and schedule specialty referrals as advised by my provider.
- I understand that I must complete or obtain all requested documents and/or lab order requests from the office.
- I will **promptly** notify the physician if there are significant changes in my condition.
- I acknowledge that failure to follow the **"Conditions of Treatment"** may result in termination from the practice.

	Date:

Patient/Parent/Guardian Signature

Patient-Provider Partnership Agreement
Financial Agreements

Our potential office fees are as follows:
Initial Psychiatric Diagnostic Evaluation **$325**
Ongoing Care Visit, 15-20 minutes, low complexity **$150**
Ongoing Care Visit, 17-20 minutes, medium complexity **$150**
Ongoing Care Visit, 20-30 minutes **$180**
Ongoing Care Visit, 35-45 minutes **$270**
Ongoing Care Visit, 60 minutes **$325**
All Other Services, **$350**/hour, prorated in 10 minute increments
Any individual letters from my provider (including diagnosis letters) **$25** Medical records to be copied and released to me directly **$50**.
Medical records to be sent to another provider **$0**
Lengthy or comprehensive forms (including time off work or disability documents) **$45+ (**determined by the amount of time spent to complete the document)
Late Cancellation, less than 24-hour or one business day notice **$50**
Missed Appointment Fee **$50**
Check Returned for Insufficient Funds **$50**
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.

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.

I understand that Dr. Chowdhary has the discretion to terminate my patient-physician relationship from the practice if any of the following occur:

After the third missed consecutive appointment
Non-payment of account
Not following treatment recommendations
Misuse/abuse of prescribed medications
Abusive behavior/language towards office staff

	Date:

Patient/Parent/Guardian Signature

Controlled Prescription Policies

Controlled Prescription Policies (CII) prescriptions are highly controlled and followed by the State of Texas (including these 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 medication, or if you need a refill and do not have a set appointment (you may be required by the clinician to have an appointment before any refills are sent).

Guidelines regarding prescriptions, refills, and emergency medication

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 our office for your refill.** Please allow 3 to 5 business days for all refill requests. **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.

Any refill requests sent after 4pm, will be refilled the next business day.

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.

	Date:

Patient/Parent/Guardian Signature

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 designee 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.

	Date:

Patient/Parent/Guardian Signature

Consent to release patient information

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.**

Parents/Spouse/Other names

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.

Patient's Primary Care Physician

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.

Patient's Therapist

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.

Name of addt'l Person/Person's allowed to discuss my records:

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.

Patient/Parent/Guardian Printed Name **Patient/Parent/Guardian Signature**

Date: