BrainDocs, PLLC
2620 Long Prairie Road, Suite #100, Flower Mound, Texas 75022
Phone: (817) 240-0012 Fax: (972) 724-2111 braindocs@braindocspllc.net

Welcome to BrainDocs, PLLC!

We are delighted and honored you have chosen us for psychiatric services.

Attached is our patient registration forms and contract. **Kindly complete these forms before your visit.** Please bring the completed forms, **your insurance card, government issued identification, and your payment** to your first visit. You will receive a copy of the contract and all receipts (upon request). If you are unable to print or forget your copy at the time of your appointment, please come 15 minutes early to your scheduled appointment time to fill out the new patient packet.

We do not offer emergency services. If you should have an emergency before your first appointment or between appointments, please go to the nearest emergency room or call 911 for all emergencies. If you have any questions or concerns please feel free to ask.

Again, Welcome!

Sincerely,

Kiran Siddiqui, M.D. MBBS

Office Use Only: ( ) Scanned

Patient Information

Patient Name: _____ Gender: M F

DOB: (mm/dd/yy): _____ SSN: _____ Email: _____

Mailing Address: _____ City: _____ ST: ___ Zip Code: _____

Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Height: _____ inches Weight: _____ pounds

If 16 yrs or older, please list your current or most recent employer

Employer Name: _____ Position: _____

PARENT/GUARDIAN INFORMATION

Mother's Name: _____ Living with Child? YES NO

DOB (mm/dd/yy): _____ Daytime Phone #: _____

Employer Name: _____ Position: _____

Father's Name: _____ Living with Child? YES NO

DOB (mm/dd/yy): _____ Daytime Phone #: _____

Employer Name: _____ Position: _____

If Applicable, Circle One: Child is..... Adopted Under Guardian Care Under Foster Care

If so, Give Name (s) of Parent(s): _____

Primary Care Physician

Doctor Name: _____ Phone Number: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Previous Mental Health Physician

Doctor Name: _____
Phone Number: _____ Fax Number: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Preferred Pharmacy Information

Pharmacy Name: _____ Phone Number: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Primary Insurance

Insurance Name: _____Phone: _____
Mailing Address: _____
Policy Number: _____ Group #: _____ SSN: _____
Name of Insured: _____ DOB: _____
Employer Name: _____ Relationship to Patient: _____

Secondary Insurance

Insurance Name: _____Phone: _____
Mailing Address: _____
Policy Number: _____ Group #: _____ SSN: _____
Name of Insured: _____ DOB: _____

Employer Name: _____ Relationship to Patient: _____

Insurance Authorization and Assignment

I authorize BrainDocs, PLLC to release my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to BrainDocs, PLLC. I understand that I am ultimately responsible for all services weather covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for management review.

_____ _____
Name Date

Contact and Consent for Evaluation/Treatment

I, _____, ("Client/Guardian") request treatment for myself at BrainDocs, PLLC may include diagnosis, evaluation, and treatment for any medical, emotional and behavioral problem, which may be found to exist.

Liability

In consideration of services rendered, Client agrees to hold BrainDocs, PLLC blameless for any liability due to an accident, illness, injury, or incident, which may occur to Client while receiving outpatient services. Client also agrees to hold BrainDocs, PLLC free from all liability for any losses through fire or theft. Client agrees, if hospitalization or extensive medical care BrainDocs, PLLC to assist the client in obtaining appropriate medical attention. Further, the family, guardian, or Client is needed; that permission is hereby given to any agent of will assume all liability for any medical expenses, hospital care, or other expenditures without liability to BrainDocs, PLLC

Financial Responsibility

Client and/or financially responsible party have been informed that she/he is financially responsible for services received at BrainDocs, PLLC, unless payment is otherwise assured. The Client and/or financially responsible party have been further informed of all applicable co-pay fees. If, for any reason, your insurance company fails to pay any portion of the amounts we billed, you will be responsible for the balance and will be billed accordingly. All co-pays and deductible are due at the time of service. We charged $200-$350 for the initial doctor's appointment. Continue therapy, including medication management follow-ups, will be a charge of $80-$175.00. It is agreed that Client will provide BrainDocs, PLLC with a permanent contact address and telephone number.

Returned checks are assessed a $30.00 fee. You agree to pay your bill within 10 days of receipt. If payment is not received within 90 days, your account will be turned over to collections. We have the option to pursue all lawful collection procedures available and the patient/parent will be responsible for all the reasonable costs of collection, including attorney's fees incurred, if any. The minimum collection fee will be 50% of the total account balance. Unwillingness to pay may result in termination of services.

Cancellations

We see all patients on an appointment basis. If you are unable to keep your scheduled appointment, please cancel as soon as possible so your allotted time may be given to another patient. We reserve the right to charge for missed appointments no called within 24 hours. The charge is $50.00 billed to you, not the insurance. Continued missed appointments may cause patient termination.

Records/Forms/Letters

Requests for records are received from various sources. Attention to these requests will only occur when we have received a signed (by patient or parent) release of information form. There will be a separate reasonable fee that the Texas Medical Board has set. Please allow 14 business days for this request to be processed. **Forms are completed after a $30 fee.** Letters are often requested by patients (or their parents) to be sent to schools, employers, etc. You will be charged a minimum of $30.00 every time a letter is necessary.

Telephone Calls

Your calls are welcome and we will return them promptly during business hours. We do not have after hour's answering service. You must call the office and leave a voicemail message. If you need to make an appointment please call during our business hours. If you have an emergency, please call 911 or go to the nearest emergency room.

Prescriptions

To prevent error and to maintain insurance and healthcare standards most prescriptions cannot be called in to the pharmacy. **An administration charge of $10.00 for prescriptions that are misplaced lost or not filled in the 21 day time frame [expired] for controlled substances.** You must return the expired prescription and pay the fee by credit card, check or cash.

Notice Regarding RX Refills

We require **7 BUSINESS DAYS NOTICE** for prescription refills. If your pharmacy sends a fax of any refill requests to our office, please allow 72 hours for refill requests to be faxed back to the pharmacy. However, please be advised that the patient and/or guardian(s) of the patient is responsible to maintain ALL medication. BrainDocs, PLLC is NOT responsible, liable, or obligated to inform any patient and/or guardian(s) of the patient that you will need your prescription(s) replenished. You must call **7 BUSINESS DAYS BEFORE** any prescription(s) are exhausted.

-Beginning January 1, 2010, we will no longer authorize refills faxed to us from the Pharmacy when the patient has been given a prescription in the office.

Termination

Clinic policy states that the third appointment that is not kept and/or follow up with in four months will be regarded as termination of treatment on the part of the patient/client, unless we as a team have decided otherwise. It also states if a patient/client has not been seen in 6 months will automatically default as an inactive patient. If the patient/client would like to continue to be treated their scheduled appointment returning to the facility will be scheduled as a new patient. If you fail to comply with treatment recommendations termination is non-negotiable.

Confidentiality

I have further been assured that any information, knowledge, or records associated with said Client are subject to release only by my informed and written consent or by a court order, except in instances of medical emergency or suspected child or elder abuse or neglect. Your confidentiality and privacy are protected by the
following Federal guidelines: Code of Federal Regulations (CFR 42 Part2) and the Health Insurance Portability and Accountability Act (HIPAA).

Discrimination Policy

No person will be discriminated against on the basis of gender, race, religion, age, national origin, disability (mental or physical), sexual orientation, medical condition, including HIV diagnosis or because an individual is perceived as being HIV infected. A person's economic condition and financial resources may be considered in admission criteria, but economic condition will not affect the services once an individual is admitted.

By signing this document, Client acknowledges that she/he understands the policy contained herein, and that if at any time there are questions, Client may return to a BrainDocs, PLLC staff member for an explanation. Consent for treatment is made with informed consent, and as such, consent may be revoked and services discontinued at any time. By signing below, Client acknowledges she/he has read the above information and fully understands its contents.

_____ _____

Patient Signature Date

_____/_____ _____

Financially Responsible Party Signature/Relationship to Patient Date

CLIENT BILL OF RIGHTS

As a client receiving services from BrainDocs, PLLC your Client Bill of Rights will include the following:

1. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
2. You have the right to be free from abuse, neglect, and exploitation.
3. You have the right to be treated with dignity and respect.
4. You have the right to appropriate services in the least restrictive setting available that meets your needs.
5. You have the right to be told about the program's rules and regulations before you are admitted.
6. You have the right to be told before admission:
    - the condition to be treated
    - the proposed treatment
    - the risks, benefits, and side effects of all proposed treatment and medication
    - the probable health and mental health consequences of refusing treatment
    - other available treatments and which ones, if any, might be appropriate for you
    - the expected length of treatment
7. You have the right to accept or refuse treatment after receiving this explanation.
8. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).
9. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
10. You have the right to meet with staff to review and update the plan on a regular basis.
11. You have the right to refuse to take part in research without affecting your regular care.
12. You have the right not to receive unnecessary or excessive medication.
13. You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
14. You have the right to be told in advance of all estimated charges and any limitations on the length of services that the facility is aware of.
15. You have the right to receive an explanation of your treatment or your rights if you have questions while you are receiving services.
16. You have the right to make a complaint and receive a fair response from the staff within a reasonable amount of

    time.
17. You have a right to complain directly to the Texas Commission on Alcohol and Drug Abuse at any reasonable time.

    Department of Investigations
    Texas Department of State Health Services Substance Abuse Services P.O. Box 149347
    Austin, Texas 78714
    1-800-832-9623
18. You have a right to get a copy of these rights before you receive services, including the Commission's address and phone number.
19. You have the right to have your rights explained to you in simple terms before receiving services.

I (we) have received from BrainDocs, PLLC staff a clear explanation of my (our) rights in simplest terms. I (we) have received a written copy of these rights. I (we) acknowledge a clear understanding of my (our) rights.

_____ _____

Patient/Guardian Signature Date

Patient History

Personal Medical/Surgical History

Yes or No?	Y	N	If yes please list and explain:
Any history of head injury/ Concussion?			
Seizure?			
Operations?			
Currently Pregnant? (Women Only)			
Do you have any medical conditions			

PATIENT'S BIRTH & DEVELOPMENTAL HISTORY:

Any issues during pregnancy? _____

Normal delivery or C- Section. Birth weight: _____

Developmental Milestones:
Sitting: _____ Walking: _____ Talking: _____
Any Developmental Delays or Concerns? If yes, please advice
_____

Any Services Received in kindergarten and/or Elementary School? If yes, please advice
_____

Any diagnosed learning disability? If yes, please advice
_____

Please indicate if any of your (blood) relatives have had any of these concern:

	Grandparents	Parents	Aunts/Uncles	Brothers/Sister	Children
Suicide (attempt or completion)					
Alcohol/Drug Problems					
Mental Hospital (PHP, IOP, Rehab)					
Depression					
Manic or Bipolar					
Anxiety					
ADHD					
Autism Spectrum Disorder					
Hallucinations, Delusions, Schizophrenia					
Domestic Violence					
Been involved in criminal behavior/ prison time					
Any other mental illness					

Education History:

- High School _____ Year Graduated _____
- College_____ Year Graduated _____

Social History

Marital History: _____

Siblings: _____

Living Situation: _____

Abuse

Physical: _____
Emotional: _____
Sexual: _____
Alcohol: _____
Tobacco: _____
Drug Use: _____

Please check any psychoactive medication you have taken in the past. Please indicate if they were helpful or not, and why you were stopped. Put an "H" if they were helpful and "NH" if they were not helpful.

Antidepressant:		**Mood Stabilizers**:		**Stimulants:**	
Zoloft		Geodon		Ritalin	
Prozac		Abilify		Adderall	
Paxil		Depakote		Concerta	
Cymbalta		Risperdal		Vyvanse	
Lexapro/Celexa		Seroquel		Strattera	
Effexor		Lithium		Metadate	
Trazadone		Tegretol		Evekeo	
Wellbutrin		Haldol		Ritalin	
Any other medication not listed:				Quillivant	
				Intuniv	
				Kapvay	

Comments (or side effects): Please provide dates and dosages, if possible

_____
_____

Drug Allergies/ Food Allergies

Please list all know aller

Review of Symptoms					
Headaches	Yes	No	**Chest Pain**	Yes	No
Dizziness/Vertigo	Yes	No	**Nausea/Vomiting**	Yes	No
Convulsions or Seizures	Yes	No	**Abdominal Pain**	Yes	No
Vision Problems	Yes	No	**Constipation**	Yes	No
Hearing Problems	Yes	No	**Urinary Problems**	Yes	No
Smelling or Taste Problems	Yes	No	**Arthritis**	Yes	No
Thyroid Problems	Yes	No	**Walking Problems**	Yes	No
Cough/Asthma	Yes	No	**Other:**		

Presenting Information

What are the main problem(s) that brought you to the doctor?

_____

When did the problem(s) first begin?

_____

Children Rating Scale

Please answer questions 1-18 using:
A= Most of the time B= Often C= Occasionally D=Rarely E=Never

Patient Question	Parent Response	Interview Comments
INATTENTION		
1. Does your child fail to pay close attention to details or makes careless mistakes in schoolwork, work, or other activities?		
2. Does your child have trouble keeping attention on tasks or play Activities?		
3. Does your child not seem to listen when spoken to directly?		
4. Does your child not follow instructions and fails to finish schoolwork, chores, or duties in the workforce?		
5. Does your child have trouble organizing activities?		
6. Does your child avoid, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time?		
7. Does your child lose things needed for tasks and activities?		
8. Is your child easily distracted?		
9. Is your child forgetful in daily activities?		
HYPERACTIVITY		
10. Does your child fidget with hands or feet or squirms in seat?		
11. Does your child get up from seat when remaining in seat is expected?		
12. Does your child run about or climbs when and where it is not appropriate?		
13. Does your child have trouble playing or enjoying leisure activities quietly?		
14. Is your child "on the go" or often acts as if "driven by a motor"?		
15. Does your child talk excessively?		
IMPULSIVITY		
16. Does your child blurt out answers before questions have been finished?		
17. Does your child have trouble waiting one's turn?		
18. Does your child interrupt or intrude on others?		
DURATION FACTORS		
19. Have symptoms been present for at least six months?		
20. Which of the following locations are these symptoms present as well? (School & at Home)		

Prescription Policy

(Please ✓ each point to indicate you have read it)

- **You must call our office 7 BUSINESS DAYS BEFORE any prescription(s) are exhausted.**
- **Controlled Substance prescriptions expire in 21 days starting the date each prescription is valid.**
- **You must call your pharmacy and speak to someone to request CONTROLLED SUBSTANCE FILL. NOT REFILL.**
- **There is an administration charge of $10.00 for prescriptions that are misplaced lost or not filled in the 21 day time frame [expired] for controlled substances, which must be paid before a replacement prescription is sent.**
- **The patient and/or guardian(s) of the patient are responsible to maintain ALL medication.**
- **BrainDocs, PLLC is NOT responsible, liable, or obligated to inform any patient and/or guardian(s) of the patient that you will need your prescription(s) replenished.**
- **BrainDocs, PLLC and your Pharmacy will NOT advise that your CONTROLLED SUBSTANCE prescription is about to expire.**
- **If your pharmacy sends a fax of any refill requests to our office, please allow 72 hours for refill requests to be faxed back to your preferred pharmacy.**

_____ _____

Patient/Guardian Signature Date

By signing this document, the patient and/or guardian(s) of the patient acknowledges that he/she understands the policy contained herein, and that if at any time there are questions, he/she may return to a BrainDocs, PLLC staff member for an explanation. Consent for treatment is made with informed consent, discontinued at any time. By signing below, the patient and/or guardian(s) of the patient acknowledges she/he has read the above information and fully understands its contents and as such, consent may be revoked and services.

CONSENT TO RECEIVE SMS TEXT MESSAGING

APPOINTMENT ONLY

Dear patients and parent(s),

You will soon be able to receive your appointment reminders via automated SMS mobile texting in addition to the automated email reminders from our system and voice telephone calls from our office personnel.

Please be advised that ALL appointments NOT cancelled within 24 hours will be subject to a $50.00 fee.

To enable SMS Mobile Texting, please complete & sign this consent form.

Thank you!

Patient Name: _____ D.O.B: _____

Telephone Number: _____

Email Address: _____

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date
(If applicable)

By signing this document, the patient and/or guardian(s) of the patient acknowledges that he/she understands the policy contained herein, and that if at any time there are questions, he/she may return to a BrainDocs, PLLC staff member for an explanation. Consent for treatment is made with informed consent, discontinued at any time. By signing below, the patient and/or guardian(s) of the patient acknowledges she/he has read the above information and fully understands its contents and as such, consent may be revoked and services.