

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*

Please list your current or most recent employer

Employer Name: _____ Position: _____

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?

Adult Rating Scale

Please answer all questions

A= Most of the time B= Often C= Occasionally D= Rarely E= Never

Patient Question	Patient Response	Interview Comments
INATTENTION		
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?		
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?		
3. How often do you have problems remembering appointments or obligations?		
4. When you have a task that requires a lot of thought how often do you avoid or delay getting started?		
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?		
6. How often do you feel overly active and compelled to do things like you were driven by a motor?		
7. How often do you make careless mistakes when you have to work on a boring or difficult project?		
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?		
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?		
HYPERACTIVITY		
10. How often do you misplace or have difficulty finding things at home or at work?		
11. How often are you distracted by activity or noise around you?		
12. How often do you have to leave your seat in meetings or other situations in which you are expected to remain seated?		
13. How often do you feel restless or fidgety?		
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?		
15. How often do you find yourself talking too much when you are in social situations?		
IMPULSIVITY		
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish themselves?		
17. How often do you have difficulty waiting your turn in situations when turn taking is required?		
18. How often do you interrupt others when they are busy?		

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.

