Welcome to Mid Cities Psychiatry!

Mid Cities Psychiatry

In the event of a emergency situation, go to your nearest emergency room or call 911

Please allow us to thank you for choosing us as your psychiatric clinic. To serve you better, please make every effort to provide us the following at least 1 business day prior to your appointment;

- complete Registration and all other relevant forms
- complete meds-lists' name/directions/dose/durations/side effects

Our Nurse Practitioners, Physician's Assistants, Licensed Professional Counselors typically focus on comprehensive psychiatric treatment. Each Nurse Practitioners, Physician's Assistants, Licensed Professional Counselors along with Dr. Seema Kazi has specialized training in Psychiatry to deliver high quality specialty behavioral health services.

Medications and Refill Requests

- To request a refill your pharmacy MUST fax a refill request form to us at 855-295-2686 at least 4-5 business days before your medications end. Please allow at least 4 business days for refill requests to be completed.
- No refill requests will be processed on a weekend or holiday.
- CII prescriptions are highly controlled and followed by the Texas Prescription Program. A $25.00 fee will be charged for those requested between office visits.
- If you lose the prescription or need a refill; it will only be until your next scheduled appointment after provider's approval ($25.00 fee will be charged to you). If you do not have an appointment, we'll schedule an appointment for you asap.
- Some medications require a prior- authorization from your pharmacy. This may take 4-5 business days depending on your insurance.
- Patients requesting refills not been seen by a provider in last 60 days or more may be asked to make a follow-up appointment before a refill is considered.
- Patients may be considered an inactive patient if not seen by a provider or in contact with the provider in last four (4) or more months

Communication

- Our administrative staff handles all requests for appointments and correspondence. Every attempt will be made to return your call within 1 business day.
- As a general rule please use your appointment time with the provider wisely. Please discuss any questions/concerns of billing-charges or your balance/credit with our billing staff or our Practice Manager.

Termination of Physician-Patient Relationship

It is the policy of Mid Cities Psychiatry to maintain a cooperative and trusting physician-patient relationship with the patients. When such a physician-patient relationship has not been formed or the relationship is no longer proceeding in a mutually productive manner. The types of circumstances that can result in termination include but are not limited to, the following;

- Treatment / Follow-up nonadherence—Does not or will not follow the treatment plan and/or abuses the medication(s) and/or tampers with prescriptions/documents and/or repeatedly cancels follow-up visits or is a no-show.
- Verbal abuse—Patient and/or a family member and/or a friend is rude and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions, disturbs the practice's peace.
- Cannot be trusted—Deceptive and/or lies.
- Nonpayment—Failure to pay and/or consistent with our payment policy. Owes a backlog of bills and has declined to work with the office to establish a payment plan.

Guidelines for Continued Care

- Your appointment has been reserved exclusively for you and keeping your appointment is your obligation. As a courtesy, MCP will send you an appointment-reminder.
- MCP understands that your time and our providers' time is very important and that's why MCP doesn't overbook or double-book patient's appointments.
- Patients are entitled under federal law to have access to their medical records and we follow all rules, guidelines and exceptions to ensure compliance to patient's rights. Please allow at least 4 business days to fulfill your request.
- If you need a phone session with a provider, please note that you will be billed at the standard office rate.
- For FMLA/STD/LTD or other forms to be completed, an appointment with a provider to be made.
- 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 three (3) missed appointments collectively in last 90 days.

_____ (please initial)

Mid Cities Psychiatry
3801 William D Tate Avenue, Suite #800A, Grapevine, TX 76051
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

- If you (or legal counsel on your behalf) request, summon and/or subpoena the participation and/or testimony of any Mid Cities Psychiatry an employee for any reason, including participation at trial, deposition or other the court or legal proceeding, you will be required to provide said employee's hourly rate for the estimated time of participation (three (3) hour minimum) or the payment as restricted by law forty-eight (48) hours in advance of the requested participation. The Mid Cities Psychiatry's employee shall be notified as soon as possible regarding said requested participation and/or testimony but at a minimum at least five (5) business days in advance of said event. Should notice fails to be provided in such a timeframe or payment fail to be made, Mid Cities Psychiatry may seek to quash or otherwise refuse to participate, and may seek reimbursement from you of any legal fees incurred as a result of seeking court protection against such participation.

_____ (please initial)

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

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Balances / Fees / Cancellation / Rescheduling / No-Show & Professional Services

- For any canceled or rescheduled appointment within 24 business hours or in case of a no-show, $75 will be automatically charged to your credit-card on file.
- Cancellation / Rescheduling / No-Show fee is nonrefundable. Emergencies may be considered with a proof and charges may be discounted/waived at the time of next appointment.
- Missed appointments will be documented in your records. If you no-show three (3) or more appointments in a 90 days period, we are to understand that you no longer need our services and may not be able to schedule an appointment for you; may use "Termination of Physician-Patient Relationship" listed above.
- Patients who arrive more than 15 minutes after their scheduled arrival time, will not be seen, will be rescheduled and charged $75 missed appointment fee.
- MCP is under no obligation to render services to you if you cannot pay copays/co-insurance/deductibles or you are unable to clear your balance or unable to make the payment-plan. You will be rescheduled until all monies are paid or proper arrangements are made.
- We realize temporary financial problems may affect you to clear your account balance. Should this occur, please contact us ASAP to assist you.
- If the Amount due is not received by the payment-plan due date, you will be charged a late fee of $25.00. All your future appointments will be canceled any time payment-plan payment is missed.
- Upon missed payment-plan payment;
    - **your balance in full must be received before any future appointments can be scheduled**
    - **must be received by/before the 21st day of your missed payment-plan date or your past-due account may be referred to collections**
    - **your Psychiatrist-Patient relationship may be terminated.**

Cancellation / Rescheduling / No-Shows Policy

Cancellations/Rescheduling in less than 24 business hours or No-Shows will be automatically charged $75 to credit-card on file. More than 15 minutes late to the appointment will be rescheduled and will be automatically charged $75 to credit-card on file.

_____ (please initial)

Cancellation / Rescheduling / No-Shows Limit:

Cancellation / Rescheduling / No-Shows Limit per 90 days is maximum one (1) _____ (please initial)

Credit-Card Information

☐ Credit Card ☐ Debit Card

Name of Card Holder			
Card # (last 4 digits only)	XXXX-XXXX-XXXX-		
Card Expiration Date		Card Security Code	XXX

I, hereby authorize Mid Cities Psychiatry to debit my/our credit card account in the amount of $75 anytime there's a canceled or rescheduled appointment within 24 business hours or in case of a no-show.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

_____ (please initial)

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Mid Cities Psychiatry

Registration Form

DemoGraphics

Name		Male ☐	Female ☐	Date			
SS #		DOB		e-mail			
Address		City		State		Zip	
Home #		Work #		Cell #			
Employer		Spouse or Parent's Name					
Emergency Contact		Relation to Patient					
Emergency Contact's Primary Phone		Alt. Phone					
Referring MD		Primary Care Physician					
Language English ☐ | Other ☐		Ethnicity Hispanic or Latino ☐ | Not Hispanic or Latino ☐ | Unknown ☐					
Race	American Indian or Alaska Native ☐	Asian ☐	Black or African American ☐	Native Hawaiian or Other Pacific Islander ☐		White ☐	Other ☐

Self-Pay Or Insurance

Are you a self-pay? Yes ☐ | No ☐ <> If YES, please go to the next page, If NO, please continue

Primary Insurance Name _____ must attach primary insurance card

Secondary Insurance Name Yes ☐ | No ☐ _____
If YES, must attach secondary insurance card

Tertiary Insurance Name Yes ☐ | No ☐ _____
If YES, must attach tertiary insurance card

Medicare Patient
As per the policy of this clinic, Medicare patient is <u>required</u> to complete/sign "Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R131" last page of this Registration-Form.

_____ (please initial)

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Seema Kazi, MD, PA

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our Patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with us. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check (payable to Mid Cities Psychiatry), cash, debit card, Visa or Mastercard.

Your Insurance

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. **This offices' policy is to collect this co-payment when you arrive for your appointment**.

Your assistance in securing timely payments of your claims may be required. If your health plan requires that you obtain prior authorization in the form of a REFERRAL from your primary care physician (PCP), or PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.

If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send claims on your behalf. You should be aware however, that the Patients' share of the medical fees owed when using non-contracted physicians will usually be more than when using contracted physicians.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that will not be covered. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment of the balance that is designated as the Patients' responsibility is due upon receipt of a statement from our office.

We will bill your health plan for all services provided at Mid Cities Psychiatry. Any balance due is your responsibility and is due upon receipt of a statement from our office or from your insurance.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, or the parent or guardian with custody, for payments.

Keep in touch

Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. If your insurance company denies payment for services rendered by Mid Cities Psychiatry on grounds that the services are not medically necessary, this consent allows Mid Cities Psychiatry to collect payment from you for the services rendered. **You will be responsible for services not paid by your insurance**.

_____ (please initial)

By my signature below, I acknowledge and understand that it is ultimately my responsibility and obligation to be aware of my insurance's requirements, coverages, deductibles and payments.

I have read and understand the policies of the practice, and I agree to be bound by its' terms. I also understand and agree that the practice may amend such terms from time to time.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

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Seema Kazi, MD, PA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedure will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigation, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail / texts and/or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information

The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive a printed copy of this notice

Practice Duties

Law requires us law to maintain privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact us to let us know. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

_____
(please initial)

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

<><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><>

My Authorization to Release All Healthcare Information Including Mental Health

I hereby authorize the following person (s) to be involved with and receive information pertaining to my medical care including mental health. I understand that any and all information can only be given in person, and after presenting a picture ID.

I understand and agree that I have the right to revoke this authorization anytime by sending/giving a written notice to MCP. And until I revoke this authorization in writing, this authorization is valid indefinitely.

Name	Relationship

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Main Office Location
Mid Cities Psychiatry
3801 William D Tate Avenue, Suite #800A, Grapevine, TX 76051
office: (817) 488-8998 <> fax: (855) 295-2686
www.MidCitiesPsychiatry.com

Authorization to Release All Healthcare Information Including Mental Health

This is a release form for authorization of your medical information to be transferred between health care providers, health insurance companies and any other party involved in your medical care.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Social Security #	

I authorize the following facilities/hospitals and doctor(s) to release all medical information to Seema Kazi, MD dba Mid Cities Psychiatry for treatment consultation and to better manage my health.

This request includes: hospital summaries, echocardiogram reports, cardiac catheterization reports, laboratory reports, electrocardiograms, physician progress notes, labs, and any other healthcare information relating to my condition including my mental health progress notes.

I understand and agree that I have the right to revoke this authorization anytime by sending/giving a written notice to MCP. And until I revoke this authorization in writing, this authorization is valid indefinitely.

List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:

Name	Contact Information

Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

A. Notifier: Mid Cities Psychiatry 3801 William D Tate Ave, #800A Grapevine, TX 76051 (817)488-8998

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. See below below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. See below below.

D. For any mental/Behavior Health services	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. See above listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D. See above listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D. See above listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D. See above listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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Seema Kazi, MD, PA

Patient Communication Consent Form

From time to time, we may need to communicate with you and to preserve your privacy, we would like for you to indicate your preferred method for us to communicate to you. Examples of such information to be communicated include appointment dates, appointment reminders, appointment follow-up, test results, billing questions, and other information clinical in nature.

In the event that no one is available to answer your phone, we request your permission to leave certain types of information on your answering machine, voicemail, or email. Please fill out the following and then indicate your preference by checking Yes □ / No □ of the boxes below;

Name			
Add:		City/St/Zip	
Home		Cell	
E-mail		E-mail	

I give permission to Mid Cities Psychiatry personnel to leave the following forms of information pertaining to me on answering machine, voice-mail or e-mails listed below.

communication	cell #	home #	e-mail
appointment date/reminders	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
appointment follow-up	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
test results	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
information clinical in nature	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
billing questions	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐

This consent may be revoked at any time after written notification is received, except to the extent that action has been taken.

Share Your Experience With Us

Our #1 priority is your satisfaction. Your reviews are an important part of our practice. We'll send you an e-mail asking you to share your experience with us. Please note only your first name and last initial will appear on your review. Your email will not appear on the review and we will never share it with third parties.

please turn over

1. RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:
a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) Email senders can easily misaddress an email.
c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect email transmitted through their systems.
e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
f) Email can be used to introduce viruses into computer systems.
g) Email can be used as evidence in court.
h) Emails may not be secure, including at USC, and therefore it is possible that the confidentiality of such communications may be breached by a third party

2. CONDITIONS FOR THE USE OF EMAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:
a) Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.
b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
c) All email will usually be printed and filed in the patient's medical record.
d) Office staff may receive and read your messages.
e) Provider will not forward patient identifiable emails outside of Mid Cities Psychiatry without the patient's prior written consent, except as authorized or required by law.
f) The patient should not use email for communication regarding sensitive medical information.
g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted

3. INSTRUCTIONS

To communicate by email, the patient shall:
a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the email.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Provider of changes in his/her email address.
e) Acknowledge any email received from the Provider.
f) Take precautions to preserve the confidentiality of email

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with my treating physician or the Mid Cities Psychiatry Privacy Officer.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Medication Acknowledgement for Psychiatric Prescriptions

By signing this agreement, I, _____ I agree to the following:
(patient's printed name)

1. To see my psychiatrist as scheduled for Psychiatric Prescription.
2. To provide a urine sample upon request for a Urine Drug Screen, either at the office of Mid Cities Psychiatry or through an accredited laboratory within 48 hours of Mid Cities Psychiatry's request. If the Urine Drug Screen is (1) positive for substances not prescribed or (2) negative for medications prescribed by a medical professional engaged in my care and treatment, Mid Cities Psychiatry has the right to decline any further psychiatric prescription.
3. To pay all office fees at the time of my visits before the service/prescription is rendered.

_____ _____

Signature of Patient or Responsible Party (if minor Patient) Date

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Seema Kazi, MD, PA

Medication Acknowledgement for ADD

By signing this agreement, I, _____ I agree to the following:
(patient's printed name)

1. To see my psychiatrist every month for my prescription for ADD.
2. To provide a urine sample upon request for a Urine Drug Screen, either at the office of Mid Cities Psychiatry or through an accredited laboratory within 48 hours of Mid Cities Psychiatry's request. If the Urine Drug Screen is (1) positive for substances not prescribed or (2) negative for medications prescribed by a medical professional engaged in my care and treatment, Mid Cities Psychiatry has the right to decline any further ADD prescriptions.
3. To have EKG done every year by primary care physician for ADD medication and have results present/faxed to Mid Cities Psychiatry.
4. To have a physical examination yearly by my Primary Care Physician for ADD medication.
5. To pay all office fees at the time of my visits before the service/prescription is rendered.

Medication Acknowledgement for Opiate Management

I, _____ requesting that my doctor provide buprenorphine treatment for opioid _____ addiction. By signing this agreement, I agree freely and voluntarily to accept this treatment as follows:

1. To keep, and be on time to, all my scheduled appointments with the doctor and his/her assistant.
2. To conduct myself in a courteous manner in the physician's or clinic's office.
3. To provide a urine sample upon request for a Urine Drug Screen, either at the office of Mid Cities Psychiatry or through an accredited laboratory within 48 hours of Mid Cities Psychiatry's request. If the Urine Drug Screen is (1) positive for substances not prescribed or (2) negative for medications prescribed by a medical professional engaged in my care and treatment, Mid Cities Psychiatry has the right to decline any further psychiatric prescription.
4. To pay all office fees at the time of my visits before the service/prescription is rendered.
5. Not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me and I will not be given any medication until my next scheduled appointment. Urine drug screens will be random (in urina latet veritas).
6. Not to sell, share or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
7. That the use of buprenorphine/naloxone (Suboxone) by someone who is addicted to opioids could cause them to experience severe withdrawal. Stopping buprenorphine in itself can cause opiate withdrawals.
8. Not to deal, steal, or conduct any other illegal or disruptive activities in or in the vicinity of the doctor's office.
9. That my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
10. That the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
11. Not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines, such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines.
12. To take my medication as the doctor, and his/her assistant has instructed, and not to alter the way I take my medication without first consulting the doctor.
13. That medication alone is not sufficient treatment for my disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my treatment.
14. That my buprenorphine treatment may be discontinued and I may be discharged from the clinic if I violate any of this agreement.
15. That there are alternatives to buprenorphine treatment for opioid addiction including:
    a. medical withdrawal and drug-free treatment
    b. naltrexone treatment
    c. methadone treatment

_____ _____

Signature of Patient or Responsible Party (if minor Patient) Date

Generalized Anxiety Disorder Questionnaire (GAD-7)

Please select each appropriate answer in the question as to over the last 2 weeks, how often have you been bothered by any of the following problems?
Use the following scale to choose the most appropriate number for each situation….

#s	Questions	frequency			
		Not At All	Several Days	More Than Half of the Days	Nearly Every Day
1	Feeling nervous, anxious or on edge?	0	1	2	3
2	Not being able to stop or control worrying?	0	1	2	3
3	Worrying too much about different things?	0	1	2	3
4	Trouble relaxing?	0	1	2	3
5	Being so restless that it is hard to sit still?	0	1	2	3
6	Becoming easily annoyed or irritable?	0	1	2	3
7	Feeling afraid as if something awful might happen?	0	1	2	3
	Add Columns…….				
	Your GAD Scale Total Score Is….				

Anxiety level based on score is;	no Anxiety (0-4)	mild (5-9)	moderate (10-14)	severe (15-21)

Mid Cities Psychiatry
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Seema Kazi, MD, PA

Alcohol Screening Questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 Times a Month	2-3 Times a Week	4 or more Times a Week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M	0-4	5-14	15-19	20+
W	0-3	4-12	13-19	20+

Patient Health Questionnaire (PHQ-9)

Please select each appropriate answer in the question as to over the last 2 weeks, how often have you been bothered by any of the following problems?
Use the following scale to choose the most appropriate number for each situation….

#s	Questions	frequency			
		Not At All	Several Days	More Than Half of the Days	Nearly Every Day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	Add Columns…….				
	Your PHQ-9 Scale Total Score Is….				

If you checked off any of the problems,
how difficult have these problems made it for you to do your work,
take care of things at home,
or get along with other people?

Not difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	

Mid Cities Psychiatry provides Transcranial Magnetic Stimulation aka TMS Therapy.
TMS Therapy is an alternative treatment for patients suffering from depression for whom medication has proven ineffective. and provides new hope for people who want to reduce or possibly eliminate the use of prescription medications to treat their depression.
Patient agrees to be contacted by a patient advocate to know more about TMS Therapy….

_____ Yes _____ No

_____ Name of Patient _____ Date of Birth

_____ Signature of Patient or Responsible Party (if minor Patient) _____ Date

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Patient Information

Name DOB Date

Height Weight B/P Pulse

Referral Source/Name	☐ Therapist	☐ PCP	☐ Family Member/Friend	☐ Other

Reason for Visit

Medical History (*seizure disorders, diabetes, heart problems etc.)*

Psychiatric History: *(Please list any psychiatric or learning disorders including ADHD, Alzheimer's, dyslexia, depression, anxiety, eating disorders, manic depression, substance abuse)*

Family Psychiatric History

Mother	Father
Brothers	Sisters
Paternal Grandmother	Paternal Grandfather
Maternal Grandmother	Maternal Grandfather

Patient's Current Medication **(please *attach list if any*)**

Medications	**Dose**	**Start / End Date**	**Side Effects**	**Directions**
Anti-Depressant	**Dose**	**Start / End Date**	**Side Effects**	**Directions**

Medication Allergies:

Pharmacy City/ST/Phone

Surgical History	

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Patient Information (continue)

Hospitalized	

Patient's Social History	Single ☐	Married ☐	Widowed ☐				
	Separated ☐	Divorced ☐	Spouse ☐				

# of Children (boys/girls ages)	
Remarks	

Alcohol	Alcoholic ☐	Recovering Alcoholic ☐	Non Drinker ☐	Social Drinker ☐

Smoking	Current Every Day smoker ☐	Never Smoker ☐	Smoker (Current status unknown) ☐
	Current Some Day Smoker ☐	Former Smoker ☐	Unknown if ever smoked ☐

Employment	Employed ☐	Occupation ☐	Disabled ☐
	Unemployed ☐	Retired ☐	Other ☐

Substances Used:

No History of Drug Abuse ☐	Marijuana ☐	LSD ☐	Ketamine ☐

Stimulants

Cocaine ☐	Caffeine ☐	Nicotine ☐	Amphetamine ☐	Ecstasy ☐
Crack ☐	Halcion ☐	Inhalants ☐	Methamphetamine ☐	Other ☐

Depressants	Alcohol ☐	Barbiturates ☐

Tranquilizers	Valium/Ativan ☐	Rohypnol ☐	Librium ☐	Xanax ☐

Opiates	Heroin ☐	Methadone ☐	Percodan, Perocet, Oxycontin, Darvocet,Darvon ☐

Therapist / Counselor Form

FEE POLICY

As a service to you, our office will verify' your coverage including your deductible and co-payment, as well as out-of-network benefits in case we are not a provider with your insurance company or third party carrier of your benefits. We will also file your insurance claims unless you tell us otherwise. We suggest that you confirm these provisions with you insurance company. Your insurance policy is a contract between you and the Insurance company. Occasionally, Insurance companies misinform our office about patient's benefits and we do our best to acquire correct information as soon as possible.

All insurance benefits will be assigned to Seema Kazi, MD PA dba Mid Cities Psychiatry. This assignment will remain In-Effect until revoked by client in writing. Although it is possible that mental health coverage deductible may have been met elsewhere, this amount will be collected until the insurance company verifies the deductible payments. Clients are responsible for payment at the time of services. We prefer cash or personal checks, and Credit Card are accepted as a courtesy. If we have not received verification of benefits from your insurance company at the time of your first appointment, the full fee will be charged. If you have overpaid, you will be reimbursed.

Crisis calls over five (5) minutes will be considered a telephone session and will be charged accordingly. (_____) **initial here**

I understand that I am financially responsible to Seema Kazi, MD PA dba Mid Cities Psychiatry for the charges incurred by me and/or my dependents. My signature below acknowledges my total responsibility in paying for any fees not covered by my insurance company.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date

CANCELLATION POLICY

- If you need to cancel an appointment you must call at least 1 full business day prior, or you will be billed the full $75 cancellation/no show fee. (_____) **initial here**
- Patients who arrive more than 15 minutes after their scheduled appointment time, will not be seen and will be rescheduled (and assessed the $75 missed appointment fee) so that other patients can be seen on a timely basis. (_____) **initial here**
- The time has been reserved exclusively for you and your courtesy to notify of cancellations allows us to offer that time to someone else. (_____) **initial here**
- If you need disability, FMLA, or other forms completed please allow at least 4 business days for completion of those forms. There will also be the standard $25 fee for completing these forms. (_____) **initial here**
- Patients may be considered an inactive patient if not seen by a provider or in contact with the provider in last four months. (_____) **initial here**
- If a client misses two consecutive scheduled sessions without a legitimate reason, the client may be considered to have given a notice of termination of therapy. (_____) **initial here**

CONFIDENTIALITY

Our office protects the confidentiality of counseling sessions. A signed "Release for information" form is required in order to release any information about our client. All information between counselor and client is considered confidential unless:

1. The client presents a physical danger to self or others.
2. The probability of client suicide.
3. Child/Elder abuse/neglect is suspected.
4. A court order has been issued.
5. The client Is a non-emancipated minor — in which case the parents/guardians have access.

In the first three cases, the counselor is required by law to inform potential victims and legal authorities so that protective measures can be taken. (_____) **initial here**

CONSENT FOR TREATMENT

I certify that I have read this agreement and understand the office policies and hereby give my consent for Seema Kazi, MD PA dba Mid Cities Psychiatry to provide me with counseling services.

Please Note: Individual sessions are up to 55 minutes long. The process of change begins by first clearly defining the problem, and then discussing your thoughts and feelings while understanding the origin of the difficulty and developing new skills and healthy attitudes about yourself and others. Techniques may be used from a variety of theoretical backgrounds depending on your needs; Cognitive-Behavioral, Logotherapy, Client Centered, and REBT. Referrals for medication evaluation or for psychological testing may be made to assist us in the best treatment available, it is your right to know your Diagnosis and Treatment plan which will be available after the second session. (_____) **initial here**

PROFESSIONAL RELATIONSHIP

In order for your professional relationship with the therapist to be helpful and supportive, it must be free of any complications that might influence objectivity or taking unfair advantage of either party. For these reason, business, personal, or other outside relationships between the therapist and client are not permitted. This policy is in accordance with Texas State Board of Examiners of Professional Counselors Code of Ethics. The professional boundaries with your counselor must be maintained to insure professional perspective and objectivity.

Name of Patient	Date
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Counselor	Date