Perfect Balance Psychiatric Services and TMS Center

PATIENT INFORMATION

NAME: _____
(LAST) (FIRST) (Middle Initial) Preferred Name

DATE OF BIRTH (mm/dd/yy) _____

GENDER (assigned at birth): Male _____ Female _____

SOCIIAL SECURITY NUMBER _____

MAILING ADDREESS: Street _____ City _____ Zip Code _____

E mail: _____

PHONE NUMBER: (Home) _____ (Cell) _____

MARITAL STATUS: ☐ Married, ☐ Single, ☐ Divorced, ☐ Widowed, ☐ Other _____

REFERRING SOURCE: _____

EMERGENCY CONTACT: _____ Relationship _____

INSURANCE INFORMATION/ RESPONSIBLE PARTY INFORMATION

PRIMARY INSURNACE: _____

INSURANCE SUBSCRIBER: _____ SUBSCRIBER'S DOB: _____ Relationship to Patient: _____

Policy #/ Member ID: _____ Group ID #: _____

SECONDARY INSURNACE: _____

Policy #/ Member ID: _____ Group ID #: _____

PHARMACY INFORMATION

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR E-PRESCRIBING TO YOUR PREFERRED PHARMACY

PREFERRED PHARMACY NAME: _____

PHARMACY ADDRESS: _____

CITY: _____ STATE: _____ ZIP Code: _____

PHARMACY PHONE NUMBER: _____

HEATHCARE PROVIDERS

PRIMARY CARE PROVIDER: _____ PHONE: _____ FAX: _____

PSYCHIATRIST: _____ PHONE: _____ FAX: _____

THERAPIST: _____PHONE: _____ FAX: _____

I authorize release of the results of my treatment upon conclusion to:

☐ **PRIMARY CARE PHYSICIAN** ☐ **PSYCHIATRIST** ☐ **THERAPIST** ☐ **OTHER _____**

PATIENT SIGNATURE: _____DATE: _____

PATIENT MENTAL HEALTH HISTORY

Current Symptoms that brought you here: _____

When did the problems Begin? _____

Current Stressors: _____

Please review the following and check any symptoms that you have been recently experiencing:

○ Depressed mood ☐	○ Inflated Self-esteem/Grandiosity ☐
○ Sleep problem ☐	○ Decrease Need for Sleep ☐
○ Change in Appetite ☐	○ Racing Thoughts ☐
○ Decrease Interest ☐	○ Pressure to Keep Talking ☐
○ Decrease Energy ☐	○ Spending Spree ☐
○ Difficulty in Concentration ☐	○ Distractibility ☐
○ Guilt ☐	○ Impulsive Behavior ☐
○ Irritability ☐	○ Trying to do Way Too Much ☐
○ Crying Spells ☐	○ See/Hear Things that May Not be real ☐
○ Excessive Worrying ☐	○ Suspect/Believe Things that May Not be Real ☐
○ Often Tense/Keyed Up ☐	○ Cannot Stop Repetitive Thoughts ☐
○ Panic Attack ☐	○ Cannot Stop Repetitive Behavior ☐
○ Intrusive/Recurrent Memory of Past Trauma ☐	○ Binging or purging behaviors ☐
○ Nightmares or Flash backs ☐	○ Starving or restricting food intake ☐
○ Hyper Vigilant ☐ Getting startled easily ☐	○ Other – Explain Below
	_____

PAST PSYCHIATRIC HISTORY

In-Patient Psychiatric Treatment/ Hospitalizations: ☐ Yes ☐ No _____

Out-Patient Psychiatric Treatment/ PHP/IOP: ☐ Yes ☐ No _____

Past Psychiatric Medications: ☐ Yes ☐ No _____

History of Suicide attempt or active thoughts: ☐ Yes ☐ No _____

History of Violence or harm to others: ☐ Yes ☐ No _____

FAMILY HISTORY OF PSYCHIATRIC ILLNESS

Immediate Family: _____

Maternal Relatives: _____

Paternal Relatives: _____

HISTORY OF ABUSE

Physical: _____

Mental / Emotional: _____

Sexual: _____

SUBSTANCE USE HISTORY

SUBSTANCES USED	Age first started	Use Frequency	Years Used	Last use	Current use	Treatment
CANNABIS/Mj/WEED						
COCAINE						
AMPHETAMINES/METH Other Stimulants						
SEDATIVE /HYPNOTICS Xanax, Valium, Ativan						
HEROIN or OTHER OPIOIDS- Pain pills						
HALLUCINOGENS LSD, PCP, Mushrooms Ecstasy, Nitrous Oxide						
INHALANTS						
OTHER: specify						

DEVELOPMENTAL HISTORY:

Congenital Illnesses or Disorders: _____

Delays in Milestones/Language developmental Delays: _____

Learning disorders: _____

Autism Spectrum Disorders: _____

SOCIAL HISTORY

Marital Status/Relationship: _____

Education: _____

Occupation: _____

Religious Affiliation: _____

Legal Issues (Domestic Violence/ DWI's): _____

Living Situation: _____

PATIENT MEDICAL HISTORY

Primary Care Physician (please print their name) _____

Current Medical Issues: _____

Do you have any of the following medical problems?

○ **Hypertension/High Blood Pressure** ☐	○ **Constipation / Diarrhea/IBS** ☐	○ **Cancers/Malignancy** ☐
○ **Heart Disease/Chest Pains** ☐	○ **Asthma** ☐	○ **Migraine Headaches/other headaches** ☐
○ **CHF (heart failure)** ☐	○ **Chronic Lung Disease** ☐	○ **Seizures** ☐
○ **Diabetes/Borderline Blood sugars** ☐	○ **Anemia** ☐	○ **Head Injury** ☐
○ **Liver Disease** ☐	○ **Bleeding Tendency** ☐	○ **Stroke** ☐
○ **Stomach Ulcers** ☐	○ **High Cholesterol** ☐	○ **Thyroid Issues** ☐
○ **Dizziness/ Vertigo/ Balance** ☐	○ **Sexual Health issues** ☐	○ **Vision Problems** ☐
○ **Urinary Problems** ☐	○ **Arthritis / Joint issues** ☐	○ **Hearing Issues** ☐
○ **Other Medical Problems** ☐**: Please list**		

Past Surgical History: _____

Menstrual History: _____

Pregnancies: _____

ALLERGIES:

Medications: _____

Food/ Dyes: _____

Environmental: _____

CURRENT MEDICATIONS – List all your medications (including Psychiatric, Physical health, over the counter and herbal medications):

Physical Health medications: _____

Mental Health Medications: _____

Other Medications: _____

OFFICE POLICIES AND CONSENT FOR EVALUATION/TREATMENT

We are committed to providing high quality care and service to our clients. Please review our office policies, procedures and if you agree to the terms, please sign the last page of this form as your consent to treatment:

- **Office Hours and Appointments:** We provide services during our normal business hours Monday to Friday only. If we miss your call during those hours or if you leave a message after hours, we will try to respond to your call as soon as possible or on the next business day. The office is closed on all major holidays and the weekends.
- **Emergencies:** Perfect Balance Psychiatric Services is an outpatient service and we do not serve walk ins or provide Patient Crises Services, Emergency Services, Weekend, and After-Hours coverage. If you have a life-threatening emergency, please go to the nearest ER, or call 911.
- **Evaluation and follow up visits: You must present a valid Government issued photo identification and your insurance card prior to being seen at each appointment.** Scheduling a first-time evaluation does not guarantee acceptance in our practice.
- **Virtual/Tele Appointments:** We do offer Virtual/Tele Appointments in some situations using HIPPA compliant software. By signing this form, you are agreeing to receiving care through our virtual or tele options if needed and understand that it is not the same as an in-office visit. We encourage in person visits.
- **Cancellations and Missed Appointments:** If you cancel an appointment, we require a 24-48 business hour notice. **You will be charged a $50.00 fee for appointments missed or cancelled without a 24-hour notice and is payable prior to any future appointments.** These will not be billed to your insurance company and will be your responsibility. Multiple missed appointments may result in termination from our practice. Late arrivals may not be seen and may be asked to reschedule their appointment. Please be considerate to other patients' appointments and the physicians' schedule
- **Medication Refill Policy: Patient is responsible for scheduling a follow up with the provider before prescription runs out. All refills and medication changes are done during an office visit only except some schedule II-controlled substances that require monthly refills.**
- **Controlled or scheduled medications may not be replaced or refilled early. Please note there is a $10.00 charge for each controlled substance refilled outside of office visit and we require at least a 36-48 hours' notice for those requested refills. Drug screening is required every 3- 6 month without a prior notice if a controlled substance is prescribed.**
- **Medication Prior Authorization:** Medications not listed on your insurance company's preferred formulary list require Prior Authorization (PA) for Coverage. It is the patient's responsibility to inform the staff to get the PA started and allow at least 72 business hours for most authorization to be approved by the insurance company.
- **Scope Of Services:** At Perfect Balance Psychiatric Services, we do not provide any services that would be involved in Worker's Compensation Cases, Divorce/ Child Custody Cases, Fitness for Duty Evaluations, Disability Evaluation, or forms of other legal matters including testimony or reports in civil matters.
- **Paperwork:** If an exception is made for documenting a disability request or FMLA form **(for an established patient of 6 months or more at the discretion of medical provider) there is a fee of $75 documentation charge. Pre-payment is required for any paperwork and may take 10 to 15 business days for completion.**
- **Medical Records:** If you need a copy of your medical records, the office needs to have a signed notification from the patient and allow 7-14 business days to process the request along with a fee of $25 fee for first 25 pages and thereafter 25 cents will apply per page.
- **Termination:** Threats or acts of verbal/physical harm to any employee of the practice or office property will result in immediate termination of treatment and notification of the proper authorities. If a patient has not come in for 6 or more months to see the provider, they are considered to have terminated the doctor – patient relationship and need to schedule as a new patient. No prescriptions will be called for them after this period. If the provider feels the need to withdraw from providing treatment for any reason, they will inform the client by mail and will be available for 30-day emergency care only.
- **Cellular devices, Cameras, Camcorders any other recording/photography devices are prohibited during a session.**
- **Safety or Danger Concerns:** In the event your provider, in their clinical judgment believes you are a danger to self or others, by signing this consent you authorize your provider to contact either the person listed on your Release of Information form or the designated authorities to assist with the crisis.
- **Communications:** We routinely use phone, email, and text to communicate on scheduling and other matters related to our service and by signing this form patient agrees to be contacted via these channels to remind you of your appointments and address your concerns. We exercise caution on our end and do not prefer to send any Personal Health Information (PHI) via email or text and recommend patients not to send any private information to us if not it protected.

- **Financial Policy/Insurance:** Medical expenses are patient's responsibility regardless of Insurance coverage. While we verify your benefits as a courtesy, a copay or coinsurance is not a guarantee of insurance coverage or payment. All Payments are due before services provided. We accept cash, debit, or credit card (Visa, MasterCard, American Express and Discover). **CHECKS ARE NOT ACCCEPTED**. Patients are responsible for their co-payments, deductibles, and any outstanding charges at the time of service. Any balance on an account that is greater than 30 days is considered past due. Balance of services that are delayed or denied by your insurance company will become patients' responsibility after 30 days. We do not guarantee that payment will be authorized for services and are not responsible for any adverse payment decisions by your insurance company. Please provide notification of any changes in your insurance coverage 48 hours in advance of your appointment or payment in full will be required. We will collect delinquent accounts through a collection agency. In the event of account placement with a collection agency the applicable collection fee will be added to that account.

1) Patient agrees to take full responsibility for the entire amount due for all services rendered that are not covered by my insurance carrier. Patient also acknowledge that he/she are personally responsible for any deductibles, copays, or any other balance not covered by my insurance carrier.
2) Patient agrees to authorize their insurance plans to pay directly to Perfect Balance Psychiatric Services the amount due for services rendered to them. Patient hereby assigns, transfer, and sets over to Perfect Balance Psychiatric Services all their rights, title, and interest to their medical reimbursement benefits under their insurance plans.
3) Patient consents to release of any medical, mental health, or substance abuse information about the patient required by their insurance company, administrator, managed care company, or review agencies, their employees, or agents for the purpose of processing insurance claims for services rendered.

Treatment Consent:

1. Patient voluntarily consents to receive treatment in person or via Virtual or Tele options at Perfect Balance Psychiatric Services.
2. Patient consents to administration and performance of treatment/diagnostic procedures/ laboratory tests as deemed medically necessary or advisable by treating physician or their assigned designees.
3. Patient understands and agrees that they will participate in their treatment plan and their non-adherence to treatment recommendations may result in being withdrawn from care.
4. Patient also understands that they may discontinue treatment or withdraw their consent to treatment at any time.
5. Patient understands that the following types of medications are commonly prescribed to treat psychiatric conditions:
   *Antidepressants, * Antipsychotics, *Anxiolytics, * Mood stabilizers, * Stimulants.

HIPPA Privacy and Confidentiality: Patient hereby acknowledges that they have understood the privacy policy and exceptions to it as explained in the policy. Patient can be provided a copy of the Perfect Balance Psychiatric Services HIPPA privacy practices policy on request.

By signing below patient acknowledges that they have carefully read and understood Perfect Balance Psychiatric Services **Office Policies and agrees to Evaluation/Treatment and Financial Obligations**. Patient understands that Office Policies and Procedures may be amended or modified from time to time by the practice.

_____ _____

Signature of Patient (Guardian's signature if patient is under 18) Date

* If you have any questions regarding any of the information on this form, feel free to discuss it with the office staff. If you would like a copy of this form for your records, Perfect Balance Psychiatric Services will be happy to provide you with one.

CONSENT FOR USING MY (PHI) FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use of disclosure of my protected health information by Dr. Lubna Siddiki for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of Dr. Lubna Siddiki. I understand that analysis, diagnosis, or treatment of me by Dr. Lubna Siddiki may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Dr. Lubna Siddiki is not required to agree to the restrictions that I may request. However, if Dr. Lubna Siddiki agrees to the restriction that I request, the restriction is binding on Dr. Lubna Siddiki. I have the right to revoke this consent in writing at any time except to the extent that Dr. Lubna Siddiki has acted in reliance on this consent.

My "protected health information" means my health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health (including substance abuse and dependence) or condition that identifies me, or there is a reasonable basis to believe the information may identify me.

I will be provided with a copy of the Notice of Privacy Practices on request by Perfect Balance Psychiatric Services PLLC and understand that I have a right to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of healthcare operations of Dr. Lubna Siddiki. The notice of privacy practices is available for review at the office and describes my rights and duties of Dr. Lubna Siddiki with respect to my protected health information.

Dr. Lubna Siddiki reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the next appointment time.

_____ _____

Patient Signature **(Guardian's signature if patient is under 18)** **Date**

CONTROLLED SUBSTANCE AGREEMENT

Please carefully read and review this controlled substance agreement and sign it so it will become part of patient record:

- **I agree to the fact that while I am receiving controlled substance prescriptions from Perfect Balance Psychiatric Services, I will not request nor accept the same controlled substance from any other physician, or individual. I understand well that it is illegal to do that and can also endanger my health.**
- **I agree not to take any "street drugs" while seeking treatment with controlled substances.**
- **I agree that taking non prescribed controlled substances, changing, or stopping medications without discussing with the provider may result in discharge from Perfect Balance Psychiatric Services or re-evaluation of my current treatment.**
- **I agree to not share, sell, trade, exchange, my prescription(s) for revenue, products, services, or in any other manner enable other individual to possess use of this (these) prescription including family members.**
- **Refills of controlled substances:**
    1. **I agree that they will only be issued during regular office hours, in person clinic visits or via pharmacy requests.**
    2. **Refill requests will not be responded at night, on holidays or weekends.**
    3. **I will keep a record of my medications and call 48-72 hours in advance If I need assistance with a controlled substance prescription.**
    4. **If I run out early, no refills will be provided. I will not take more medications than prescribed unless I speak with my doctor first.**
    5. **I understand that if my medication is in short of supply at the pharmacy, I will wait for the refill or call the pharmacy ahead of time to make sure the medication is available. The provider's office cannot guarantee a supply at my pharmacy and will not be changing pharmacies on immediate requests.**
    6. **All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed ahead of time.**
    7. **I agree to pay a service fee of $10 per script on schedule 2 controlled substances issued without an in office or in person visit.**

- **If a controlled substance prescriptions or medication is lost, misplaced, or stolen, I understand that it will not be replaced.**
- **I agree to keep and/or maintain this (the prescription(s) in a secure and safe location.**
- **I acknowledge and agree to notify clinic of any new medications as well as any medical conditions and/or adverse effects experienced from any of the medications.**
- **I have been fully informed by my provider that the medication could be habit forming and addictive in nature.**
- **I understand that with some controlled substances I cannot suddenly stop the medication I may have to slowly taper under medical supervision, or I may have Withdrawal symptoms.**
- **I understand the importance of following my treatment as directed and permit Drug screenings without prior notice and Prescription monitoring to track consumption of prescribed controlled substances and to screen for the use of illegal substances. Refusal to consent to such testing shall subject you to a medication taper schedule and may result in the discontinuance of your prescription.**
- **I understand that If I violate any of the above policies the patient's pharmacy, local authorities, Primary care physician and DEA will be notified and all orders for prescriptions will cease, and patient will be dismissed from the care of Perfect Balance Psychiatric services immediately.**

My signature indicates my approval to all the above statement as part of Controlled Substance Agreement.

Patient Signature _____ **Date _____**

(Guardian's signature if patient is under 18)

9300 John Hickman Pkwy, Suite 101
Frisco TX 75035

TEL. # (972) 781-0100, FAX # (972) 781-0101

Perfect Balance Psychiatric Services and TMS Center

AUTHORIZATION TO RELEASE /OBTAIN PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME: _____ **DOB**: _____

I hereby authorize PERFECT BALANCE PSYCHIATRIC SERVICES PLLC to use disclose, obtain, or release my protected health information (medical records) to/from the named individual or organization listed below. Please fully complete the form. Incomplete forms will be null and void.

☐ **COPY OF COMPLETE MEDICAL RECORDS**

☐ **COMPLETE BILLING RECORDS**

☐ **ALL PHARMACY/ PRESCRIPTION RECORDS**

☐ **ALL DISABILITY, PERSONAL AND WAGE RECORDS**

THIS PROTECTED HEALTH INFORMATION IS DISCLOSED FOR THE FOLLOWING PURPOSES: _____

I consent my PHI disclosed to the following individuals:

1) _____ _____ _____

FULL NAME **RELATIONSHIP** **TELEPHONE NUMBER/FAX NUMBER**

2) _____ _____ _____

FULL NAME **RELATIONSHIP** **TELEPHONE NUMBER/FAX NUMBER**

3) _____ _____ _____

FULL NAME **RELATIONSHIP** **TELEPHONE NUMBER/FAX NUMBER**

- **I understand that specific information to be disclosed may include Drug, Alcohol Abuse or Mental Health Treatment, information regarding communicable diseases including Human Immunodeficiency Virus (HIV), acquired immunodeficiency syndrome (AIDS), and other medical conditions, laboratory results, treatment and any such related information.**
- **I understand that the information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.**
- **I authorize that a photocopy of this authorization is acceptable as an original.**
- **This authorization will remain in effect indefinitely unless revoked in writing. I understand that my treatment is not conditioned upon my providing this authorization. I understand that I have the right to revoke the authorization at any time by providing a written notification to: The Privacy Officer, Perfect Balance Psychiatric Services, and 9300 John Hickman Parkway, Suite 101, Frisco, Texas 75035. Perfect Balance Psychiatric Services shall not be deemed responsible for release of any information pursuant to this authorization prior to revocation.**
- **I understand that there will be a charge of release of photocopies of my medical record. Please indicate below if you need the photocopies of your medical record to be sent to the above named individual or organization.**

SIGNATURE OF THE PATIENT: _____ DATE: _____
(Guardian's signature if patient is under 18)

PATIENT NAME: _____

CLIENT BILL OF RIGHTS

As a Patient receiving services at Perfect Balance Psychiatric Services, we respect, protect, implement and enforce your bill of rights which includes the following:

1. **You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your health needs.**
2. **You have the right to be free form 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 settings available that meets your needs.**
5. **You have the right to accept or refuse treatment after receiving this explanation.**
6. **If you agree to treatment or medications, you have the right to change your mind at any time (**unless specifically restricted by the law**)**
7. **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.**
8. **You have the right to meet with the staff to review and update the plan on a regular basis.**
9. **You have the right to refuse to take part in research without affecting your regular care.**
10. **You have the right to not receive unnecessary or excessive medication.**
11. **You have the right to have information about you kept private and to be told about the times when information can be released without your permission.**
12. **You have the right to be told in advance of all the estimated charges and any limitations on the length of services that the clinic is aware.**
13. **You have the right to receive any explanation of your treatment or your rights if you have questions while you are in treatment**
14. **You have the right to make a complaint and receive a fair response for the clinic within a reasonable amount of time.**
15. **You have the right to complain directly to the Texas Commission on Alcohol and Drug Abuse any reasonable time.**
16. **You have the right have your rights explained in simple terms before receiving services**
17. **You have the right to request a copy of these rights including the address and phone number of Texas Commission on Alcohol and Drug abuse.**

Department of Investigations
Substance Abuse Services
PO BOX 149347
Austin, Texas 78714
1-800-832-9623

I hereby agree that I have received a clear understanding of my rights at Perfect Balance Psychiatric Services and if I desire, I can be given a copy of these rights for myself.

PATIENT SIGNATURE_____ **DATE_____**
(Guardian's signature if patient is under 18)

STAFF SIGNATURE_____ **DATE_____**