PATIENT INFORMATION SHEET

(PLEASE PRINT AND COMPLETE ALL SECTIONS FRONT AND BACK)

EMERGENCY CONTACT PERSON:

EMERGENCY PHONE NUMBER:

IF PATIENT IS A MINOR PLEASE CHECK THIS BOX ☐

SECTION A — PATIENT INFORMATION

PATIENT ACCOUNT #	SOCIAL SECURITY #
PATIENT'S LAST NAME:	
PATIENT'S FIRST NAME:	
PATIENT'S MIDDLE INITIAL:	GENDER (please check one box): ☐ MALE ☐ FEMALE
DATE OF BIRTH (MM/DD/YY):	AGE:
ADDRESS:	

CITY:	STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:	CELL PHONE:

MARITAL STATUS (please check one box): ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

EMPLOYER:	EMPLOYER ADDRESS:
PRIMARY CARE PHYSICIAN (P.C.P.):	
REFERRED TO OUR OFFICE BY:	

SECTION B — ADDITIONAL INFORMATION

(PLEASE COMPLETE IF PATIENT IS A MINOR)

FATHER'S NAME:	MOTHER'S NAME:

PARENTS ARE (please check one box): ☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED

IF PARENTS ARE DIVORCED OR SEPARATED; ABSENT PARENT(S) ADDRESS & PHONE NUMBER:

SECTION C — BILLING INFORMATION

(PERSON RESPONSIBLE FOR BILL, IF DIFFERENT THAN ABOVE)

NAME:		
ADDRESS:		
CITY:	STATE:	ZIPCODE:
HOME PHONE:	WORK PHONE:	CELL PHONE:

RELATIONSHIP TO PATIENT (please check one box): ☐ SPOUSE ☐ MOTHER ☐ FATHER ☐ SELF ☐ OTHER:

SOCIAL SECURITY #	EMPLOYER:

SECTION D — INSURANCE INFORMATION

PRIMARY INSURANCE INFO		SECONDARY INSURANCE INFO	
COMPANY:		COMPANY:	
ADDRESS:		ADDRESS:	
INSURED (NAME ON CARD):		INSURED (NAME ON CARD):	
I.D. #	DATE OF BIRTH (MM/DD/YY):	I.D. #	DATE OF BIRTH (MM/DD/YY):
GROUP #		GROUP #	
GROUP NAME:		GROUP NAME:	

SECTION E	AUTHORIZATIONS

MEDICARE PATIENTS ONLY

ONE TIME AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to Ralph Bharati M.D., P.A. for any services furnished by that provider. I authorize any holder of medical information about me to release to the Health Care Financial Administrations and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature:_____ Date Signed:_____

Please INITIAL all sections:

_____ CONSENT TO TREAT: I hereby grant consent for treatment or services to be provided by Ralph Bharati M.D., P.A. I also certify that no guarantee or assurance has been made as to the results which may be obtained.

_____ RELEASE OF MEDICAL INFORMATION: I consent to the release of my medical records by Ralph Bharati M.D., P.A. for the purpose of review or audits or for necessary insurance purposes to authorized representatives of my insurance company or managed care organization.

_____ PATIENT RIGHTS: I acknowledge that I have received, read & understood Ralph Bharati M.D., P.A. Client Rights & Responsibilities.

_____ NOTICE OF INFORMATION POLICY: I acknowledge that I have reviewed the Ralph Bharati M.D., P.A. Notice of Information Policy posted in the reception room.

_____ PAYMENT / INSURANCE PAYMENTS OF BENEFITS: *I understand I am responsible for all charges for services and treatments rendered. However, as a courtesy and on my behalf, Ralph Bharati M.D., P.A. will bill my insurance company; I understand that I am responsible for deductibles, co-pays, or any amount not covered by my insurance.* I authorize payment of benefits to be made on to Ralph Bharati M.D., P.A. for medical services provided.

_____ CANCELLATION/NOSHOW POLICY: You must provide a minimum of 24 hours notice to cancel or reschedule your appointment. Any appointment that is cancelled/rescheduled with less than 24 hours notice or missed without notification (NO SHOW), will be charged a $60.00 LATE CANCELLATION/NO SHOW fee. The LATE CANCELLATION/NO SHOW fee is the sole responsibility of the patient/guardian, and must be paid in full before the patient's next appointment.

_____ NO SHOW DISMISSAL POLICY: If patient does not provide notification for not being able to attend his or her appointment (NO SHOW) for three (3) or more scheduled appointments, then that patient may be terminated/dismissed as a patient from Ralph Bharati, M.D, P.A.

By signing below, I agree to all of the terms stated above:

Patient's Signature:_____ Date Signed:_____

Insured's Signature:_____ Date Signed:_____
(if other than the patient)

Parent or Guardian's Signature:_____ Date Signed:_____
(for patients under 18 years old)

PSYCHOSOCIAL ASSESSMENT

Date:_____

Client Name: _____ Date of Birth: _____ Age: _____ Sex:_____

Race: _____ Marital Status: _____ City of Birth: _____

MEDICATION ALLERGIES: _____

History of Problem (Emotional problems, behavioral, professional or social life):

Medical History (Physical health problems, surgeries, hospitalizations):

Family history (Mental illness, substance abuse, physical health problems or psychotropic medications):

Alcohol/Drug/Tobacco Use:

Family History (Significant others, parents & siblings-names, ages & place of residence):

Number of Marriages (Length) / Children (Ages/Parent with whom they reside):

Educational History / Employment History (Current & past employment):

Legal History (past & current):

Traumatic Events (of childhood, adolescence & adulthood):

Ethnic/Cultural/Religious Factors (spiritual orientation & influence on identity, values & beliefs):

PAST PSYCHIATRIC HISTORY

Client Name: _____

Have you received Psychological or Psychiatric Evaluations in the past? Y N
If yes, list name of doctor, period of time you saw this doctor and types of services received.

1._____

2._____

3._____

Have you been hospitalized for mental health or chemical dependency in the past? Y N
If yes, list name of hospital, where it was located, when you were hospitalized, your doctor & diagnosis.

1._____

2._____

3._____

Have you received therapy or counseling in the past? Y N
If yes, list name of professional, where & when you saw them.

1._____

2._____

3._____

Have you been on psychiatric medications in the past? Y N
If yes, please list names of medication, dosage, doctor who prescribed, period of time you took the medication and any side effects you experienced.

1._____

2._____

3._____

4._____

5._____

6._____

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

INFORMATION REQUESTED FROM:		INFORMATION RELEASED TO:	
		RALPH BHARATI M.D., P.A. / S.T.O.P.	
NAME/INSTITUTION		NAME/INSTITUTION	
		8911 EAST ORME, STE A	WICHITA, KS 67207
ADDRESS	CITY/STATE/ZIP	ADDRESS	CITY/STATE/ZIP
		316-686-7884	316-686-0036
TELEPHONE	FAX	TELEPHONE	FAX

INTIAL HERE:_____ RECIPROCAL RELEASE AUTHORIZATION (two-way exchange of information)

I hereby authorize the disclosure of the information checked below from the records of:

_____ _____
Patient Name Date of Birth

_____ _____
Address Date of Treatment

_____
City/State/Zip

Initial All Applicable:

_____Psychiatric information including written reports

_____Medical history, physical exam, lab reports for last year

_____Psychological testing information

_____Verbal communication

_____Substance abuse evaluations & treatment records

_____HIV/AIDS Information

_____Other:_____

_____Hospital treatment
(Check all that apply)

___Admit/Discharge Summary
___History & Physical
___Progress Notes
___Medical Orders
___Lab Data
___Bio-psychosocial Assessment

The purpose of this requested release is: ***Coordinate Treatment Services***

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and as protected health information as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that my treatment will not be conditioned upon signing this authorization and I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Upon completion of treatment services at Ralph Bharati, MD,PA
(Specification of the date, event, or condition upon which this consent expires)

PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2, 42 USC) PROHIBIT ANY PARTY FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION, IF HELD BY ANOTHER PARTY, IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MOR THAN $500 IN THE CASE OF A FIRST OFFENSE, AND NOT MORE THAN $5000 IN THE CASE OF EACH SUBSEQUENT OFFENSE.—Drug Abuse Office & Treatment Act of 1972 (21 USC 1175) Comprehensive Alcohol Abuse & Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 USC 4582) Federal Register, Vol. 40, No. 127—Tuesday, July 1, 1975; Health Insurance Portability and Accountability Act of 1996 (42 USC).

Signature of Patient (14+ years)	Date	Signature of Parent/Legal Guardian	Date
Witness	Date	Printed Name of Parent/Legal Guardian	Relationship

Client Rights & Responsibilities

PSYCHIATRIC & ADDICTION services
Ralph Bharati M.D., P.A.

As a client at Psychiatric and Addiction Services, you have the following rights:

- Being treated by all medical providers and staff with respect and dignity while maintaining all information confidential unless a written consent form is provided by the client or client's guardian.
- You will not be denied treatment based on your race, creed, religion, political affiliation, gender, or sexual orientation.
- You have the right to terminate treatment at any time.
- You will be informed of alternative forms of treatment if you request it.
- You will participate in the development of your treatment plan.
- Your account will be handled with honest and precise billing practices that comply with all local, state, federal, and/or insurance company regulations.
- You have the right to report complaints to management (Medical Director or Office Manager).
- You are advised that mental health/substance abuse providers are mandated by law to report suspected child abuse or neglect, in addition to any serious threats to harm yourself or others to the appropriate state or local authorities.

As a client at Psychiatric and Addiction Services, you have the following responsibilities:

- Attend all scheduled appointments or give at least 24-hours notice for cancellations (if we do not receive 24-hours notice, your account will be charged $60.00 late cancellation / No Show fee).
- Provide your complete medical history to your treatment provider.
- Discuss any life decisions with your treatment provider before taking any action.
- Be open and honest when speaking with your treatment provider.
- Deal realistically with your problems or issues; accepting that there will be ups and downs in treatment.
- Respect the confidentiality of other clients with whom you may come into contact with in the office.
- Complete any assignments that treatment providers ask of you.
- Practice good financial management – as most insurance have a deductible and co-pay, it is important to understand your insurance benefits; especially mental health/substance abuse benefits since they are usually different from your other medical benefits. **Please be prepared to pay your co-pay prior to each visit**. Financial plans with flexible terms are available; ask our staff how you can participate. If your balance is delinquent (more than 30 days) and no financial plan has been agreed to, excess fees may be charged to your account (i.e. collection costs and/or reasonable attorney fees).