Today's Date: _____ Name of Provider:_____

Joshi & Merchant, M.D., P.A.
PATIENT DATA & CONSENT FOR TREATMENT

PATIENT INFORMATION					
Name (Last, First, Middle)		**SS#**	**Birthdate**	**Sex**	
Street Address	**City, State, Zip**		**Primary Care Physician:** **Phone Number:**		
Home Phone	**Cell Phone**	**E-mail**	Driver's License #	State of License	
Marital Status	Student Status	Smoker (Y/N)?	Emergency Contact	Relationship of Contact	Phone of Emer. Contact

Primary Employer	Secondary Employer (If Applicable)
Address of Employer	Address of Employer
City, State, Zip	City, State, Zip
Work Phone	Work Phone

RESPONSIBLE PARTY INFORMATION (if different than above)			
Name (Last, First, Middle)	SS#	Birthdate	Sex
Street Address	City, State, Zip	Relationship to Patient	
Home Phone	Cell Phone	Driver's License	State of License

PRIMARY INSURANCE		
Name of Insurance Company	Policy #	
Name of Insured	Group #	
Address of Insurance Company	Copay Amount $	
City, State, Zip	Phone	Deductible $
Relationship to Patient	Effective Date	Expiration Date

SECONDARY INSURANCE (If Applicable)		
Name of Insurance Company	Policy #	
Name of Insured	Group #	
Address of Insurance Company	Copay Amount $	
City, State, Zip	Phone	Deductible $
Relationship to Patient	Effective Date	Expiration Date

A. Reason For Visit

1. Please describe the **MAIN PROBLEM THAT BRINGS YOU TO OUR OFFICE** _____

_____

2. **WHO REFERRED YOU TO OUR OFFICE**

_____Phone:_____

B. Psychiatric Care

1. Have you ever received psychological, psychiatric or counseling services before? □ No □ Yes If yes, please indicate:

When?	From Whom?	For What?	With What Results?

2. Have you ever taken any medications for psychiatric or emotional problems? □ No □ Yes If yes, please indicate:

When?	From Whom?	For What?	Which Medication?	With What Results?

3. Is there a history of psychiatric illness in your family? □ No □ Yes If yes, please explain:

_____

4. Depression Questionnaire

I am unable to do the things I used to do.	☐ No	☐ Yes	I feel hopeless about the future.	☐ No	☐ Yes
I can't make decisions.	☐ No	☐ Yes	I feel sluggish / restless.	☐ No	☐ Yes
I am gaining/losing weight.	☐ No	☐ Yes	I get tired for no reason.	☐ No	☐ Yes
I am sleeping too little (or too much).	☐ No	☐ Yes	I feel unhappy.	☐ No	☐ Yes
I think about killing myself.	☐ No	☐ Yes			

5. Alcohol Questionnaire

Have you ever felt that you ought to cut down your drinking?	☐ No	☐ Yes
Have people annoyed you by criticizing your drinking?	☐ No	☐ Yes
Have you ever felt bad or guilty about your drinking?	☐ No	☐ Yes
Have you ever had a drink first thing in the morning?	☐ No	☐ Yes

6. Drug Screen

Have you ever missed / abused a prescription drug?	☐ No	☐ Yes
Have you ever gone to different doctors to get the same prescription?	☐ No	☐ Yes
Do you use recreational drugs?	☐ No	☐ Yes
Does your drug use cause problems in your family or employment?	☐ No	☐ Yes
Has your drug use ever led to legal problems?	☐ No	☐ Yes

C. Medical History

1. Please list here any close relatives who have had the following illnesses.

Family History

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Allergies/Asthma				High blood pressure			
Anemia				Kidney disease			
Arthritis				Nervous/Mental Disturbances			
Bleeding Tendencies				Stroke			
Cancer/Tumors				Tuberculosis			
Diabetes				Ulcers			
Heart Disease				Other (specify)			

2. **CIRCLE** any of the following medical problems you have had, or still have.

Measles	Heart problem, murmur	Dizziness/Fainting
Rubella (3-day Measles)	High blood pressure	Arthritis/Joint problems
Mumps	High cholesterol	Back pain
Chickenpox	Ulcer/Heartburn/Stomach problems	Cancer of _____
Rheumatic fever	Gall bladder problems	Diabetes
Tuberculosis	Kidney stones or diseases	Sickle cell anemia
Eye or vision problems	Urine infections	Hypoglycemia
Ear infections/Hearing loss	Sexually transmitted diseases	Easy bruising or bleeding
Sore throats	AIDS (HIV)	Depression/Anxiety
Sinus infections	Thyroid problem	Eating disorder
Persistent cough	Allergies/Hay fever	Other _____
Asthma	Frequent headaches	
Bronchitis/Pneumonia	Seizures/Epilepsy	

3. Please list here any **HOSPITALIZATIONS, OR SURGERIES**. If none, write "none".

_____

_____

4. **LIST ANY MEDICATIONS** you are receiving regularly and include reason and dosage:

_____

_____

5. LIST ANY FOOD-DRUG ALLERGIES

_____

6. List any handicap that may require special consideration.

_____

D. Other Information

Is there any other information that we should be aware of? _____

_____

E. Patient Rights

I understand that my provider will work with me to develop a treatment plan that is best suited for me. If a serious situation arises, I understand I should contact my provider immediately. I understand that I have the right to be informed of my progress and to review, add or correct information in my medical record and to get copies for other professionals to use. I understand that I have the right to get information about my provider's qualifications, including his/her license, education, training, experience and special areas of practice. I understand that my insurance plan can help to define what services are covered and which are not. I also understand that I can ask my provider about fees, appointment scheduling and office policies. I understand that I have the right to get respectful treatment at all times and to report any immoral or illegal behavior by my provider.

F. Consent to Treatment

I acknowledge that the information I provided is correct and that I understand my rights as a patient. I do hereby consent to take part in treatment by Joshi & Merchant, M.D., P.A.

_____ _____

Print Name of Patient or Responsible Party **Relationship to Patient**

_____ _____

Signature of Patient or Responsible Party **Date**

PATIENT AGREEMENT AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I agree to take full responsibility for the fee for services rendered and have reviewed the most recent fee schedule.
- I hereby authorize this office to apply for benefits on my behalf for covered services rendered.
- I request payment from my insurance to be made to Joshi & Merchant, M.D., P.A.
- I understand that I am responsible for any portion of the charges not covered by my insurance; this includes but is not limited to the fees not covered in order to meet my deductible, benefits not covered, benefits exhausted or expired, reduced and/or no benefits because patient or responsible party failed to pre-certify treatment with insurance company.
- **I agree to pay all deductibles and copayments at time of service. If my copay amount is not known at the time of my first visit, I agree to pay a minimum of $20.00.**
- **I agree to pay the full fee at time of service if I have not obtained the required insurance authorization.**
- I authorize the release of medical information to my insurance company in order to determine insurance benefits to which I am entitled.
- I authorize a copy of this authorization to be used in place of the original.
- This authorization may be revoked by myself or my insurance company at any time in writing.
- **I agree to keep all scheduled appointments and to cancel by noon the day before my appointment. I understand there will be a non-negotiable charge for all missed medication appointments of $60 and $70 for therapy appointments. I understand that physicians and therapists recognize missed appointments as a compliance issue and grounds for termination of treatment.**

I hereby authorize Joshi & Merchant, M.D., P.A. and the parties listed below to release to each other in writing or by telephone all information and records pertaining to my history, symptoms, diagnosis, functioning, treatments and prognosis. These parties are: (*Please initial each choice and specify name)*

	Specify Name	Initial		Specify Name	Initial
Insurance Carrier			Mental Health Professional		
Previous Psychiatrist			School		
Primary Care Physician			Employer		
Spouse			Other		
Children			Other		

Our practice believes that a good provider / patient relationship is based upon understanding and open communication. Our staff is available to answer any questions you may have about your insurance benefits or to clarify any misunderstandings you may have regarding your balance. Please notify us immediately if there is a discrepancy on your statement as we do not adjust accounts beyond ninety days. If you notice that your insurance company has not paid, please also contact your insurance company immediately. To facilitate your ability to pay for services rendered, we accept cash, checks, Mastercard, Visa, American Express & Discover. There is a $35 charge for all bounced checks.

I agree to pay all charges in full within 30 days of billing invoice. I understand that services and fees unpaid after that time are subject to interest and a minimum processing fee of $1 per month. I understand that if my account becomes delinquent, the account will be turned over to a collection company and/or attorney and I will be responsible for the balance due and all applicable finance charges, all third party collection company fees and/or attorney's fees up to an additional 50% of the total balance outstanding. In addition to these fees, I will pay all court costs, filing fees and processing fees. I also understand that if collection proceedings begin on my account, I will be unable to be followed within the practice of Joshi & Merchant, M.D., P.A.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

Joshi & Merchant, M.D., P.A.
HIPAA 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. You do not need to respond to this notice.

Our Responsibilities

Protected Health Information (PHI) is any individually identifiable health information. This information includes demographics, for example, age, address, e-mail address, and relates to your past, present or future physical or mental health or condition and related health care services. We are required by law to:

- Maintain the privacy of protected health information
- Provide you with this notice of our legal duties and privacy practices of your PHI
- Follow the terms of our notice that are currently in effect
- Communicate any changes in the notice to you

How We May Use and Disclose Protected Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Protected Health Information" or "PHI"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our office.

Treatment/Research. We may use and disclose PHI for your treatment and to provide you with treatment/research-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. Before we use or disclose PHI for research, the research project will go through a special approval process. Even without special approval, we may permit interoffice researchers/research assistants to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any PHI.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and/or disclose PHI to contact you and to remind you that you have an appointment with us. We also may use and/or disclose PHI to provide you with information about treatment alternatives or health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter/postcard about our office and the services we offer. These may be sent to you through the USPS with our practice information on the envelope/postcard.

Health Care Operations/Individuals Involved with Your Care. We may use and disclose PHI for health care operational purposes or to those that may be involved with your potential participation in a research study. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that may have an interest or relationship with you as a result of your (potential) participation in one of our research studies. (For example, the Food and Drug Administration, Pharmaceutical Company/Sponsor, IRB/Ethics Committee and/or any other related company) for their health care operation activities.

Special Situations

As required by Law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Your Rights

You have the following rights regarding the PHI we have about you:

Right to Inspect and Copy. You have a right to inspect and copy PHI that may be used to make decisions about your care. This includes medical notes/records. To inspect and copy this PHI, you must submit your request, in writing to our office. As required by law, there are restrictions on disclosing mental health information to patients as well as other entities. We also reserve the right to charge a reasonable cost-based fee for making copies.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, health care operations or for which you provided written authorization. To request an accounting of disclosures, you must submit your request, in writing to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment/research or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse or significant other. To request a restriction, you must submit your request, in writing to our office. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your participation in a research study or other medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must submit your request, in writing to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.docjoshi.com. To obtain a paper copy of this notice, please contact anyone in our office at 301-317-6575.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Protected Health Information (PHI) we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

This notice became effective on April 14, 2003. If you have any questions, please contact us at 301-317-6575.

Questions and Complaints

Questions concerning this notice should be directed to our privacy officer at (301) 317-6575. You can also view this notice online at www.docjoshi.com. If you believe your privacy rights have been violated, you may file a written complaint. Any complaints should be in writing, state the nature of the complaint, and how to contact you. You will not be retaliated against for filing a complaint, and your complaint will not affect your diagnosis or any treatment we are providing you. You may send your complaint to our office or the Secretary of the Department of Health and Human Services.

Joshi & Merchant, MD, PA
5500 Knoll North Drive, Suite 290
Columbia, MD 21045
301-317-6575 / 301-317-9376 Fax

Secretary of Health and Human Services
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257 or 877-696-6775
email: HHS.mail@hhs.gov

Acknowlegement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient: _____

Signature of Patient/Guardian _____

Date: _____