



Please tell us how you heard about us.

Referring Physician Name : _____
 Radio TV Pamphlet Search Engine
 Other, Please specify : _____

PATIENT INFORMATION

Date : _____
 Patient : _____
 Last First MI Preferred Title
 Male Female Child* Student** Single Married Divorced Widowed

*If Child, Provide Parent / Guardian Names(s) below:

**If Student, Please complete: Full time Part time

Parent / Guardian Name(s)

Relationship

School / Location

Patient Date of Birth: _____ Patient SSN : _____
 Address: _____
 City: _____ State : _____ Zip: _____
 Home Phone # _____ Cell # _____ Fax # _____
 Referral ? Yes No Referred by : _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person.

Name: _____ Relationship: _____ Phone # _____

EMPLOYEMENT INFORMATION

Employer : _____ Occupation : _____
 Address: _____
 City: _____ State : _____ Zip: _____
 Work Phone # _____ ext _____ Direct # _____ Fax # _____

INSURANCE INFORMATION

Insured : _____
 Last First MI Preferred Title
 Insured's Date of Birth : _____ Insured's SSN : _____
 Insured's Employer : _____
 Patient's relationship to Insured : Self Spouse Child Other (Please specify) _____

PRIMARY INSURANCE CARRIER: _____

Member ID # _____ Group / Policy # _____
 Address : _____
 Customer service # _____ Provider service # _____

SECONDARY INSURANCE CARRIER: _____

Member ID # _____ Group / Policy # _____
 Address : _____
 Customer service # _____ Provider service # _____

PREVIOUS PHYSICIAN INFORMATION

Provider: _____ Telephone : _____
 Clinic / Facility : _____
 Address : _____
 City : _____ State : _____ Zip : _____
 Reason for changing : _____

PREVIOUS PHYSICIAN INFORMATION

Provider: _____ Telephone : _____
 Clinic / Facility : _____

MEDICAL HISTORY

General Health : Excellent Good Fair Poor
 Y N Under a physician's care now? _____
 Y N Any hospitalization in the past 5 years? _____
 Y N Any serious illnesses / surgeries? _____
 Y N Use tobacco in any form? If yes, Type : _____
 Y N Is pre-medication required before medical visits due to heart condition or artificial joint? _____
 Y N Taking any prescription or daily OTC medications/drugs? If yes, please explain in the Medication Section.

Female patients: Y N Currently Nursing? Y N Currently Pregnant? Due Date : _____

Do you know of any reason why routine medical procedures might pose a risk to you, our staff or other patients? Y N
 If yes, please describe : _____

Is there anything important about your medical condition we have not asked? Y N
 If yes, please describe : _____

ALL PATIENTS : Do you have, or have you ever had any of the following? (Check all that apply) NONE

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cancer / Malignancy | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiation / Chemo |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Convulsions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Autism / Asperger's | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Other – Please list : _____ | |

ALL PATIENTS : Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply) NONE

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Lactose Tolerance	<input type="checkbox"/> Sleeping Pills
<input type="checkbox"/> Anesthetic – Local	<input type="checkbox"/> Dairy	<input type="checkbox"/> Metal Sensitivity	<input type="checkbox"/> Sulfa Drugs
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Latex	<input type="checkbox"/> Nitrous Oxide Sedation	<input type="checkbox"/> Penicillin / Other Antibiotics
<input type="checkbox"/> Other – Please list : _____			



MEDICATION INFORMATION

ALL PATIENTS : Are you currently taking any of the following? (Check all that apply): NONE

- Antibiotics / Sulfa Drugs Antihistamines / Allergy Daily Aspirin Blood Pressure Medications
- Blood Thinners Cancer / Chemo Medication Cortisone/Steroids Heart Medication / Digitalis
- Insulin Nitroglycerin Oral Contraceptives Osteoporosis Medications
- Other (Please list below)

Drug Name	Dosage	Reason Prescribed

PHARMACY INFORMATION

Pharmacy Name : _____

Pharmacy Address: _____

Phone # : _____ **Fax # :** _____



Psychiatric Medical Associates, P.A.
Mukeshkumar Delvadiya, M.D.
6404 International Pkwy, Suite # 1010, Plano, TX 75093
Phone # 972-267-1988 Fax # 972-267-3434

**Psychiatric Medical Associates, P.A.
Notice of Privacy Practices**

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Psychiatric Medical Associates, P.A. at 972-267-1988.



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- 4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Psychiatric Medical Associates, P.A. at 972-267-1988. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact 972-267-1988. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact 972-267-1988.

I _____ authorize Psychiatric Medical Associates, P.A. to release all information regarding my treatment to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I hereby acknowledge that I have been presented with a copy of Psychiatric Medical Associates, P.A.'s Notice of Privacy Practices.

Signature

Date

Printed Name



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Psychiatric Medical Associates, P.A.
General Office Policies and Procedures & Financial Agreements

Thank you for choosing Psychiatric Medical Associates, P.A. to be of service to you and your family for your behavioral healthcare needs. Please read these policies completely, and if you have any questions, do not hesitate to ask for clarification.

Appointments: Appointments are scheduled according to each patient's needs and the availability of the provider. The time of your appointment is reserved for you. You are expected to give 24 hours' notice with a staff member or with the answering service if you will not be keeping your appointment, **or it will be necessary for you to pay an unkept appointment fee of \$50.** Your insurance company will not cover this fee. It is your responsibility. Repeated "no show" or "late cancelled" appointments could result in you being referred out of the clinic to another practitioner. We do not do phone appointments. In case of an emergency, where you cannot come to your regular scheduled appointment and you have to do a phone appointment, you will be charged \$135 for the appointment. We cannot bill your insurance for the phone appointments, it is your responsibility.

Maintaining Patient Status: In our area of healthcare, it is very important that you be seen on a regular basis. At the end of each appointment, the doctor / nurse will tell you how long a period of time they would like you to schedule a follow-up appointment in the office. We urge you to make the follow-up appointment before you leave our office in order to schedule the most convenient time for you. **If you fail to keep and/or maintain follow-up appointments for a period of 120 days or greater, we will conclude that you have terminated the patient-physician relationship.**

Phone Calls: Emergency calls are handled as a priority. If you are experiencing a medical emergency, please call 911 immediately. Routine calls will be handled by our office staff during our normal business hours. Please leave a message on our voice mail or with our after-hour's answering service for the office staff. Your call will be returned on the next business day. Calls that require the doctor to call you back will be handled as timely as possible. Please leave your name, number and detailed message with our 24 hours answering service if your call is urgent and cannot wait until the office is open. Medication refills/pre-authorizations/scheduling appointments **are not considered emergencies**, so please do not have the doctors paged for such services.

Medication Refills: We handle all refills during your regularly scheduled appointments. If a medication refill becomes necessary, please provide us with your pharmacy phone number, medication name and how you are currently taking your medication. We will require you to make an appointment, and we will call in enough medication to last until your appointment. **There is a \$30 fee for medication refill requests between appointments.**

- **On the first appointment, prescription for 30 days will be given. We cannot give 90 day Rx on the initial visit.**
- Patients can be given 90 days Rx on their subsequent visits if required by their insurance companies. Patients are expected to keep their scheduled appointments even though they have enough medications. If you cancel or reschedule your appointment because you have 90 days Rx from previous visit, you will not be given another 90 days Rx in future.
- We appreciate your cooperation in keeping track of your medication supply in order to avoid running out. Refills will normally be handled within 3-5 business days (not including holidays and weekends).
- If you need your medication adjusted or would like to be started on a new medication, we request that you make an appointment with your provider. We will not be able to change the medication / dosage over the phone.
- Our providers require that you keep scheduled appointments as directed, generally every 2-3 months, to keep current as a patient. Your eligibility for prescription refills is determined by keeping scheduled appointments.
- We do not provide refills for medications after hours or on weekends. For your convenience, you may leave a message on our voice mail or with our answering service, but requests are handled during administrative office hours only.
- If a controlled substance / narcotic / stimulant is prescribed to you, it is understood that we are the only provider providing this medication to you. If you obtain this medication (or similar medication) from another provider, without our knowledge, we will no longer provide prescriptions for this medication, and we may be forced to terminate the doctor-patient relationship.



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- Prescription refills for ADD/ADHD medications must be written monthly by the doctor and must be picked up at the office by the patient or an authorized representative. Or we will mail the prescription to the patient's address on file.
- Our office does not refill medications for lost or stolen controlled substance prescriptions. If your prescription or medication is lost or stolen and you have difficulty with withdrawal symptoms, you should go to the nearest emergency room.
- **For expired prescriptions for ADD/ADHD medications, a \$15.00 fee will be assessed for re-writing the Rx.**

Prior Authorization for medications: Your doctor prescribes medication based on your condition/illness. Sometimes your insurance company limits the availability or free access to certain medications. At times, they may require two copays. These type of restrictions are between you and your insurance company. You need to contact your insurance company if this issue arises. If they require clinical information from the prescribing physician, ask them to fax us a written request. You are required to provide them with your medication history, ID numbers etc. **Please allow us 48-72 hours to get your prior authorization for medication.**

Payment for the services: Payment for the service is due at the time of service. Any past due balance needs to be paid before the next visit. We may need to cancel your appointment if you are unable to pay your balance in full prior to your next visit. We will send two monthly statements and one final collection letter and if the balance is unpaid, it may be turned over to outside collection agency. If you are unable to pay your balance in full, we can offer you a "No interest" payment plan where the minimum payment should be \$100 per month and/or balance will have to be paid off in six installments / six months. First payment is due on the day payment plan is set up. Payment on the payment plan statements will be considered separate than you current visit costs which needs to be paid at time of service, regardless of your payments towards payment plan.

Credit Card on file policy: We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of \$25 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Patients with insurance plans under Obamacare / Affordable Care Act, will have to pay the full visit cost upfront for each visit. We will bill your insurance, and if the insurance pays for the visit and doesn't ask for refund/recoupment in 4 months after your visit, we will refund you the credit.

Other Fees

Medical records, disability forms, work excuses, school notes, calls to employers, return to work letters, etc. will be provided on a fee basis. **The fee must be prepaid in order for us to complete the requested task.** The fee will be based on time spent preparing the requested information.

Medical Records: There will be a charge of \$40.00 for the first 20 pages and \$1.00 per page for every copy thereafter for medical records. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery. **Please note it will take 7-10 business days for processing the records.**



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Letters/ Documentation: There is a charge associated with any and all documentation that we may have to complete. The charges will be determined by the amount of time spent to complete the request.

FMLA/Disability Paperwork: We **DO NOT** do FMLA/Disability paperwork. In rare case, if we fill out FMLA/Disability paperwork, there will be a charge of \$40 that you will have to pay. We will not be able to bill your insurance or your employer for that.

Court Fees: If a deposition or opinion in court is required, there is a \$300 per hour charge for the Nurse Practitioner and \$500 per hour for the MD to go to court. The minimum charge is \$1000 paid in advance. The hourly charge is billed for preparation time, travel time, and any time spent with an attorney/ clerk for preparation. Travel costs (i.e. tolls, gas, and miles) will also be billed to you. Your insurance company will not be billed for any of these fees and you are solely responsible for them.

All fees, including late cancellation and no show fee, are not final and subject to change at any time without notice based on the discretion of the practice.

I have read, understood, and agreed to the policies listed above for Psychiatric Medical Associates. I accept the conditions for receiving service from Saumil Mehta, M.D., Sejal Mehta, M.D.,M.B.A. and the Nurse Practitioners.

Signature

Date

Printed Name



Medication Consent Form

I have received education regarding the medication that has been prescribed to me, my child, or a person for which I am the legal guardian by and I consent to the administration of this medication. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication. I have also been informed of the reason or intended purpose for which this medication is prescribed. I am aware that the U.S. Food and Drug Administration (FDA) may not have approved this medication to be prescribed for this particular condition or for a patient of this age. I understand this medication education.

- ❖ It is recommended that women who are or may become pregnant, or are breastfeeding, discuss this with their practitioner before taking any medication and to notify their practitioner immediately upon becoming pregnant.
- ❖ If prescribed benzodiazepines or psychostimulants DO NOT USE with alcohol or operate an automobile/heavy machinery. In addition, DO NOT take within 3 hours of narcotic pain medications.
- ❖ If the patient experiences any side effects from the medication prescribed, it is recommended that patient notify their practitioner immediately.
- ❖ During the patient’s appointment, the practitioner will obtain a thorough patient history. Please let the practitioner know about the following:
 - Current medications (prescription, over-the-counter, herbs, etc.) the patient is taking
 - Food and drug allergies of the patient
 - Any medical conditions of the patient

Patient / Legal Guardian Signature

Date

Provider Signature

Date

Patient Name _____

Date of Birth _____



RULES FOR CONTROLLED PRESCRIPTIONS

Patient Name : _____ DOB : _____

You have elected to start yourself or your child on a medication that is a controlled substance. These medications are frequently used for the treatment of ADHD/ADD. These medications are controlled by the Drug Enforcement Agency. There are multiple rules and regulations regarding these medications. By signing this document, you are acknowledging and agreeing to follow the rules regarding these medications.

1. These prescriptions can ONLY be written during an office appointment. They cannot be called into a pharmacy. You cannot receive this medication outside of an appointment. If there is an extenuating circumstance that does require medication outside of an appointment, there will be a \$30.00 fee for the prescription.
2. The prescription expires 21 days from the “earliest fill date”. You agree that if you allow a script to expire, there will be a \$15.00 fee to rewrite the prescription. This courtesy will only be offered one time. It is your responsibility to assure you fill your prescriptions on time. You will also only be given enough prescription to hold you until the next appointment.
3. We must see you at least once in maximum of every 90 days in order to prescribe this medication. Please keep scheduled appointments.
4. You agree to not ask any other provider to fill this type of medication while you are being treated by our providers.
5. If you have a script that expired, you agree to bring it in to your next appointment. Please do not destroy it. We are required to be accountable for all controlled prescriptions that leave this office.
6. If your script is lost or stolen, the DEA requires that we have a police report on file prior to writing a new script.
7. You agree to NOT share or sell this medication to anyone.

I have read, understood, and agreed to the policy listed above for Psychiatric Medical Associates, P.A.

Signature of patient / legal guardian

Date

Name of patient / legal guardian



Release of Information Form

By the signature below, I hereby authorize Psychiatric Medical Associates to release and obtain information with respect to any physical, psychiatric, or drug/alcohol related condition obtained during the course of diagnosis and/or treatment to/from individual(s) or healthcare provider(s) below. The type of information authorized includes, but may be limited to, that which is indicated below.

RELEASE TO/OBTAIN FROM		INITIAL EACH SPECIFIC CONSENT TO RELEASE
By identifying and initialing below you are giving the provider permission to release and/or obtain medical records, reports of testing, most recent progress notes, treatment plans, medications, and lab reports.		
Family Members or Significant Others	Name/Relationship:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number:	
	Name/Relationship:	
	Contact Number:	
School RN/School Counselor	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
Therapist/Counselor	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
PCP	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
Employer/HR Department	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
Attorney	Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
Tx Dept of Family and Protective Services CPS	Case Manager Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	
Other	Name/Relationship:	<input type="checkbox"/> Yes <input type="checkbox"/> No Initial _____
	Contact Number/Fax:	

I understand that this authorization is voluntary and made at my discretion. I may cancel/revoke this authorization at any time by giving written notice of my desire to do so. By initialing and signing I have given consent for both verbal and medical records to be released to/obtained from the identified individuals.

Patient Name

Patient Signature

Date of Birth

Signature of parent, guardian or authorized representative (if applicable) Date



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CREDIT CARD ON FILE POLICY

At Psychiatric Medical Associates, P.A., we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of \$25 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Psychiatric Medical Associates, P.A. to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Visa Mastercard Discover American Express

Credit Card Number _____

Expiration Date ____ / ____ / ____ **CVV # (Security code on back of card)** _____

Cardholder Name _____

Billing Address _____

City _____ **State** _____ **Zip** _____

Signature _____

I (we), the undersigned, authorize and request Psychiatric Medical Associates, P.A. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Psychiatric Medical Associates, P.A.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Psychiatric Medical Associates, P.A. in writing and the account must be in good standing.

Patient Name (Print): _____ **Legal Guardian Name (Print):** _____

Patient Signature: _____ **Legal Guardian Signature:** _____

Date: ____ / ____ / _____