PSYMEDSOLUTIONS
Dr. Satish Narayan, M.D. & Dr. Nisha Satish, M.D.

7170 Preston Road Ste. 200 • Plano, Texas 75024 • Tel (972) 232-7474 • Fax (972)-232-7401
4501 Joe Ramsey Blvd E Ste. 260 • Greenville, Texas 75401 • Tel (903) 455-4300 • Fax (903) 455-4301
7273 Hawkins View Drive • Fort Worth, Texas 76132 • Tel (972) 232-7474 • Fax (817) 438-6730

PATIENT REGISTRATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **Social Security #:** _____ **Sex: Male ☐ Female ☐**

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ **Race:** _____ **Ethnicity:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: Cell: _____ **Home:** _____ **Work:** _____

Preference for appointment reminder: Home ☐ Work ☐ Cell ☐ **May we leave a voicemail message? Yes ☐ No ☐**

Are you Employed: Yes ☐ No ☐ **A Full Time Student: Yes ☐ No ☐** **Disabled: Yes ☐ No ☐** **Retired: Yes ☐ No ☐**

Email Address: _____

Name of Employer: _____ **Phone:** _____ **Fax:** _____

Is the patient a minor? Yes ☐ No ☐ - ***If Yes, please fill out the information below:***

Parent(s)/Guardian(s) Name: _____ **Date of Birth:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Guardian Phone Number: Cell: _____ **Home:** _____ **Work:** _____

*****If the patient has been appointed a court-appointed guardian, the guardian must be present for all appointments and must sign all signature required documents. ***If the court-appointed guardian is not present, the appointment will be rescheduled.**

EMERGENCY CONTACTS AND OTHER CURRENT PHYSICIANS

Spouse's Name: _____ **Phone #:** _____

Name: _____ **Relationship:** _____ **Phone #:** _____

Name: _____ **Relationship:** _____ **Phone #:** _____

Primary Care Physician: _____ **Phone #:** _____

Specialist Physician: _____ **Phone #:** _____

Specialist Physician: _____ **Phone #:** _____

Counselor/Therapist: _____ **Phone #:** _____

INSURANCE INFORMATION

PRIMARY	SECONDARY
Primary Insurance: _____	**Secondary Insurance:** _____
Subscriber ID#: _____	**Subscriber ID#:** _____
Group#: _____	**Group#:** _____
Plan Name: _____	**Plan Name:** _____
Policy Holders Name: _____	**Policy Holders Name:** _____
Policy Holders DOB: _____	**Policy Holders DOB:** _____
Policy Holders SS#: _____	**Policy Holders SS#:** _____
Relationship to Patient: _____	**Relationship to Patient:** _____

I certify that the information provided above is complete and accurate to the best of my knowledge.

_____

Signature of Patient or Patient Representative **Date**

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Authorization to Disclose Health Information
Medical Records Release

Patient Name (Please print) ____________ Date of Birth ____________

Social Security Number ____________ Phone Number ____________

I HEREBY AUTHORIZE DISCLOSURE OF INFORMATION TO/FROM THE NAMED INDIVIDUALS OR ORGANIZATION(S) LISTED BELOW:

Full Name or Person/Organization/Physician's Office ____________ Relationship to Patient ____________ Phone Number ____________

[ ] Release all Health Information
[ ] Release all Billing Information (including payments, collections, etc.)
❑ DO NOT SPEAK/RELEASE INFORMATION TO ANYONE
[ ] Release Other (Please specify): ____________

Full Name or Person/Organization/Physician's Office ____________ Relationship to Patient ____________ Phone Number ____________

[ ] Release all Health Information
[ ] Release all Billing Information (including payments, collections, etc.)
❑ DO NOT SPEAK/RELEASE INFORMATION TO ANYONE
[ ] Release Other (Please specify): ____________

Full Name or Person/Organization/Physician's Office ____________ Relationship to Patient ____________ Phone Number ____________

[ ] Release all Health Information
[ ] Release all Billing Information (including payments, collections, etc.)
❑ DO NOT SPEAK/RELEASE INFORMATION TO ANYONE
[ ] Release Other (Please specify): ____________

- **I understand that incomplete forms will be null and void; no exceptions.**
- I understand that disclosure of my health information does not include mailing or faxing copies of my medical records; I must complete a medical records release in order to have copies of my medical records mailed or faxed to the named individual(s) or organization(s).
- I understand that specific information to be disclosed may include history of Drug or Alcohol Abuse or Mental Health Treatment, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Immune Deficiency Syndrome (AIDS), laboratory test results, treatment progress, and any other such related information. **This authorization will expire 1 year from the date of my signature.**
- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I further authorize that a photocopy of this authorization is acceptable as an original.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
- The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: Privacy Officer: 7170 Preston Road Suite 200, Plano, TX 75024 Phone: 972-232-7474 Fax: 972-232-7401.

Print Patient Name ____________ Patient/Guardian Signature ____________ Date ____________ Relationship ____________

Witness Signature ____________ Title ____________ Date ____________

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Office Polices

Office Hours and Emergencies

Our office hours are Mon through Fri, 8 AM to 5 PM. Our office is closed on all major holidays. We do not provide emergency services, crisis services, weekend, or after-hours coverage. If you have a life-threatening emergency, please go to the nearest emergency room or call 911. Our providers are able to treat patients at Carrolton Springs Hospital and Mesa Springs Treatment Center.

Consent for Treatment

I authorize the physicians and clinic personnel of Psymed Solutions to conduct physical examinations and routine services, order and perform tests, and administer any treatment deemed necessary by the examining physician. Should treatment be performed, the physician will fully inform me as to the nature of the procedure, the alternatives to treatment, and the risks involved. I will be given the opportunity to ask questions and have my questions answered. Should special procedures be indicated, I understand that the examining physician will discuss this with me, and that additional consent(s) may be required.

Insurance

Medical expenses are the patient's responsibility regardless of insurance coverage. While we will attempt to verify your benefits with your insurance company as a courtesy, any copay, coinsurance and deductible information provided to us from your insurance company is not a guarantee of insurance coverage or payment. If the patient has a secondary insurance policy, once the primary insurance carrier has made their payment, we will file your claims as a courtesy to your secondary insurance. If we do not receive payment after forty- five (45) days from the date we filed the claim, the balance will become the patient responsibility. Patients are responsible for knowing the stipulations of their insurance policy. If for some reason your insurance company fails to pay for services rendered and/or you are not eligible at the time the services are rendered, the patient is still responsible for payment. You also agree to take full responsibility for the entire amount due for any and all services rendered that are not covered by your insurance carrier. You are responsible to timely notify our office for any changes of insurance or demographics information.

Assignment of Benefits

I authorize my insurance carrier(s) to remit payment of benefits for any claim to Psymed Solutions. I understand that any ineligible or non-covered expenses are my responsibility. I assign Psymed Solutions, as an Authorized Representative to: (1) Submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) Submit any and all requests for benefit information from my insurance company, (3) Initiate formal complaints to any state or federal agency that has jurisdiction over my benefits, and (4) Release all medical information necessary to process my claims. I authorize any plan administrator or insurer to release any and all plan documents, insurance policy, and/or settlement information upon written request from Psymed Solutions. This assignment is valid for all administrative and judicial reviews under all applicable federal and/or state laws. A photocopy of this assignment is to be considered as valid as the original.

Medication refill policy

You are responsible for scheduling a follow-up with your provider before any prescription runs out. All refills and changes in medications are done during an office visit. If a refill is needed outside of an office visit, request your pharmacy to send over the request electronically and allow 42-72 hours to process. We only provide treatment and medication management for controlled substances (Suboxone, Adderall, Ambien, etc.) during an appointment. It is the patient's responsibility to take the medication as prescribed. Early refills will not be made before the refill date and is the provider's discretion to approve or deny refill requests. Unless you are directly approved by a provider at your appointment that you can be seen every 90 days, your medication will get denied for refill.

Cancellations and missed appointments

If you need to cancel an appointment, a 24-business hour notice is required. If you miss or cancel an appointment without a 24-business hour notice, you will be charged $50 for the missed appointment. Missed appointments cannot be filed with insurance, therefore you are solely responsible for this fee. After 3 missed appointments, we will no longer provide services unless all missed appointments are paid in full.

Medication Prior Authorization

Prior authorization requests need to be sent to our office by the pharmacy electronically. Please allow 42-78 hours for your insurance to process the request. We advise each patient to obtain a copy of your formulary list prior to your visit, to ensure that the medications being prescribed are covered by your insurance company, and to give you the opportunity to discuss alternatives if possible. This will help to avoid charges incurred secondary to this policy.

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Paperwork

There is a $25.00 charge for all Short Term and Long Term Disability, FMLA, ADA Accommodations or other paperwork that require a physician to complete. Please present your paperwork to the receptionist prior to your appointment. It's at your provider's discretion to complete it or not. All paperwork will require 7 business days to be completed, regardless of the due date as it is the patient's responsibility to get the paperwork to us in a timely manner.

Returned checks

There is a $30 charge for any returned checks.

Medical records

If you need a copy of your medical record, you must give Psymed Solutions office a signed records request/release from the patient. Fees for medical records are $25.00 for the first 20 pages, and $0.50 for each page thereafter and may take up to 15 business days to obtain.

Labs and Injections

We may need to order labs (ex. Drug Screens, Bloodwork, etc.) and/or give medication injections (ex. Vitamin B12, Antibiotics, Steroids, etc.) in some cases. Please note the cost of the labs and injections are not included in your visit charges. Your insurance may not cover these services and will be the patient's financial responsibility. PsyMed Solutions has partnered with LabCorp and Quest Diagnostics for our patient's lab work. We have an on-site lab in our Plano location and are happy to assist our patients with this convenience when ordered by our physicians.

Communications

We may contact you by (telephone, mail, email) to provide appointment reminders, information regarding medical advice or results or any other health related services that may aid in your care.

Confidentiality

We are required by law and regulation to protect the privacy of your medical information as outlined in Psymed Solutions privacy practices. Psymed Solutions notice of privacy practices can be viewed on our website, at the front office of all clinic locations and a paper copy is able to be provided to the patient anytime per their request.

Danger

In the event that your provider, in their clinical judgment believes you to be a danger to yourself or to someone else, by signing this consent you authorize Psymed Solutions to contact either the person listed as your emergency contact or someone else to provide assistance through a crisis situation. If at any time a patient shows hostile or threatening behavior to the employees or patients of Psymed Solutions, the police will be contacted and the patient will no longer be able to receive care at any Psymed Solutions clinics.

Right to withdraw

If a conflict arises for the client or the physician/provider, either has the right to withdraw from the treatment. If the provider feels the need to withdraw from providing treatment, Psymed Solutions will inform the patient and will try to provide appropriate referrals and 30-day emergency care.

By signing below, you acknowledge that you have read and understand the policies listed above. Furthermore, you give authorization of payment of medical benefits to our office for services rendered. Terms and condition are subject to change.

Patient Name (Please Print) _____ Date _____

Signature of Patient or Guardian _____ Relationship _____

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Agreement for Controlled Substances

It is our desire to provide you with excellent patient care and to help you achieve overall health and wellness. To help achieve that goal, your provider may prescribe a Controlled Substance medication (i.e., narcotics, sedatives benzodiazepines, stimulants and/or buprenorphine) which can be very useful, but have a significant potential for misuse and are, therefore; closely controlled by local, state, and federal authorities. In addition, the Texas Medical Board encourages urine drug screens in conjunction with a controlled substance contract to start or continue taking any controlled substance. Failure to sign and abide by this agreement will result in immediate termination of any controlled substances being prescribed by any provider in this office. Please carefully read through the entire agreement and initial by each item and fill your name in, indicating that you understand these requirements set forth by all PsyMed Practitioners. We look forward to working with you.

Sincerely,
Satish Narayan, M.D., Staff, & PsyMed Solutions

1. I am responsible for my medications. If the medications are lost, misplaced, or stolen, **REGARDLESS OF THE REASON**, I understand that my physician **WILL NOT** be *replacing or refilling* my medication. I further understand that *early refills* **WILL NOT** be approved. **(INITIAL)** _____

2. I **WILL NOT** seek medications from any other physician or practitioner while I'm receiving the same medications from my provider of PsyMed Solutions. **We will regularly check the Texas Prescription Monitoring Program data base. The data base tells your provider of each prescription for controlled substances that you have filled from all practitioners and pharmacies. (INITIAL)** _____

3. **Suboxone Patients:** I **WILL NOT** seek opiate medications from any other physician or practitioner while I'm receiving Suboxone therapy from my Provider of PsyMed Solutions. I further agree to inform my Provider of PsyMed Solutions of any and all medical or dental procedures that will require the use of opiate medications. I agree to disclose to the surgical or medical physician that I am on Suboxone therapy and will sign a Release of Information for the physicians to consult regarding medications and all surgical or medical procedures. **(INITIAL)** _____

4. Concerning refills: I agree that refills of **controlled substance medications will be made during regular office hours, in person, during a scheduled visit. It is your responsibility to take the medication as prescribed. Early refills will not be made, even if you have run out of your medication early. (INITIAL)** _____

5. **I WILL TAKE my medications as prescribed** and as directed. I will not take *extra* medication without being advised to do so by my provider at PsyMed Solutions. By doing so ensures that I will not run out of medications early. **(INITIAL)** _____

6. I **WILL NOT** use any illicit drugs, as defined by law. These include marijuana, heroin, methamphetamine, cocaine, PCP and hallucinogens or any other mood-altering substance that is illegal. **(INITIAL)** _____

7. I understand that PsyMed Solutions will perform urine drug screening tests, at my expense, to verify compliance of my medication contract. If I am found to be using illegal substances for any reason, my Controlled substance medications will be discontinued immediately. **NO EXCEPTIONS**. In addition, if my urine drug screen is negative for medications prescribed by PsyMed Solutions practitioners, my controlled substances medications will be discontinued immediately and will not be re-prescribed by any physician at PsyMed Solutions. **NO EXCEPTIONS**. **(INITIAL)** _____

8. I understand that if I violate any of the above conditions, my controlled substance prescriptions will be immediately terminated, and it will be reported to my other healthcare providers, medical facilities and pharmacies. **(INITIAL)** _____

9. I understand that my provider may discontinue my medication at any time if they no longer think it is clinically appropriate or in my best interest. Additionally, if my controlled substances are discontinued by my PsyMed Solutions provider, this will apply to all other PsyMed Providers as well. **No other practitioner in this practice will restart you on the medication. Lastly, once you have violated the agreements in this contract at no time will you ever be prescribed controlled substance by this practice again. (INITIAL)** _____

I acknowledge the receipt of this agreement and that it has been explained to me in detail by a staff member at PsyMed Solutions. I understand by signing below, I agree to comply with the terms and guidelines of this agreement.

Patient Name (Please Print) _____ Date _____

Signature of Patient or Guardian _____ Relationship _____