1110 Druid Circle
Lake Wales, Florida 33853
Ph: 863.605.8262 Fax: 727.733.6002
www.lakewalespsychiatry.com

Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information. All information will be confidential.

Please Print:

Date:_____ Patient's Name:_____

SSN:_____ Sex: Male ◯ Female ◯ DOB:_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____ Cell:_____

Employer:_____ Work Phone:_____

Business Address:_____

City:_____ State:_____ Zip:_____

Spouse / Parent Name:_____ Contact Number:_____

Emergency Contact:_____ Emergency Number:_____

Referred by:_____

Responsible Party

Person Responsible:_____ Relationship to Patient:_____

Address:_____ City:_____

State:_____ Zip:_____ Driver's License #:_____ State:_____

Phone:_____ DOB:_____ Employer:_____

Insurance Information

Name of Insured:_____ Relationship to Patient:_____

DOB:_____ SSN:_____ Employer:_____

Date Employed:_____ Work Phone:_____ Insurance Company:_____

ID #:_____ Group #:_____ Plan:_____

Address:_____ City, State, Zip:_____

How much is your deductible?_____ Has it been met?:_____

Pharmacy Name:_____ Phone:_____

Address:_____ City, State, Zip:_____

I authorize release of any information concerning my healthcare, advice, treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____

Signature of Parent / Guardian Date

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CONSENT FOR TREATMENT

As a condition of my treatment with Dr. Dinar Sajan, M.D., I hereby agree to the following:

Consent for Treatment: I hereby authorize Dr. Dinar Sajan, M.D., and / or any treating physician or clinician in charge of my care, to oversee my treatment plan and monitor my behavioral health medication as required by my behavioral health symptoms.

Authorization to Release Behavioral Health Information: I hereby authorize Dr. Dinar Sajan, M.D., and / or any physician or clinician, treating for my care, only such diagnostic or therapeutic information (including psychiatric, drug abuse, alcohol, of HIV status) as may be necessary to determine benefits and to process payment claims for behavioral health services provided to me commencing on this date. This authorization will be valid only for the period of time necessary to process payment claims pertaining to this treatment. I hereby authorize Dr. Dinar Sajan, M.D., and / or any treating physician or clinician to release information from my medical records to other health care facilities or providers to which I may be transferred for emergency services.

Medicare / Medicaid / Patient Certification / Release Information & Payment Request:

I certify that the information given to me in apply for payment under the **Title XVII and / or XIX**, of the **Social Security Act** is correct. I authorize a holder of behavioral health information about me to release to the **Social Security Administration** or its intermediaries or carriers, any information needed for this or a relation **Medicare** claim. I request that payments of authorized benefits are made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to **Medicare or Medicaid** for payment to me. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY HEALTH INSURANCE DEDUCTIBLES AND CO– PAYMENTS.**

Assignment of Insurance Benefits: I hereby authorize, request and direct any and all assigned insurance companies to pay directly to **Health and Psychiatrist Consultants, LLC,** or any treating physician the amount due mien pending claims for these behavioral health benefits under the respective policies. I agree that should the amount be insufficient to cover the entire expense, I will be responsible for payment of the entire bill.

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CONSENT FOR TREATMENT (continued)

Guarantee of Payment: For value received, the undersigned does agree and promise to pay **Health and Psychiatrist Consultants, LLC** and/or any treating physician/clinician all charges and expenses incurred on the treatment of the named patient, including expenses not covered by insurance policy presently in force. If any action at law or inequality is brought to enforce the agreement, **Health and Psychiatrist Consultants, LLC** and/or any treating physician/clinician will be entitled to reasonable attorneys' fees, court costs, and any other costs of collection incurred. I understand that all bills are payable and become due upon presentation.

Denial of Payment Authorization: Health and Psychiatrist Consultants, LLC will make every effort to obtain payment/authorization/preauthorization for all managed care contractual agreements. If however, a denial is received, the patient/guarantor/will be responsible for all incurred charges and penalties.

Receipt of Patient's Rights and Responsibilities, Notice of Privacy Practices and Orientation/Welcome Guide: By my signature on this document, I acknowledge receipt of a **Patient's Rights and Responsibilities** pursuant to **Florida State 381.026**, a **Notice of Privacy Practices**, and a copy of the **Orientation/Welcome Guide** prior to, or at the time of admission.

An Itemized Statement is Available Upon Request.

Release of Responsibility and Liability for Personal Valuables: I understand and agree that **Health and Psychiatrist Consultants, LLC** is not responsible for personal valuables or belongings brought into, or claimed to be brought into, the office at **1110 Druid Circle** – **Lake Wales, Florida 33853** by named patient/ client or his/her agent.

I understand that, under the direct supervision of my treating physician, a physician assistant/Ph.D. may be utilized in my care and treatment.

I have read this contract and understand it. I will receive a copy upon my request.

_____	_____	_____
Patient Signature	Parent / Guardian Signature	Date
_____		_____
Witness Signature		Date

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Health & Psychiatrist originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- ☐ A basis for planning my care and treatment
- ☐ A means of communication among the many health professionals who contribute to my care
- ☐ A source of information for applying my diagnosis and surgical information to my bill
- ☐ A means by which a third-party payer can verify that services billed were actually provided
- ☐ And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writhing, except to the extent that the Practice has already taken action in reliance there on.

Notification of Family Members: Please share information with

_____

I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____ _____

Signature of Patient or Legal Representative Date

_____ _____ _____

Signature Title Date

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CONTROLLED SUBSTANCE AGREEMENT

We at Health & Psychiatry, Dr. Dinar Sajan's Office, we are committed to doing all that we can to treat your Chronic Medical Condition. In some cases, Anxiety, Sleeping Aids and Anti-Depressants are used as a therapeutic option in the management of medical conditions such as anxiety disorders, sleep disorders and depression which are strictly regulated by both State and Federal Agencies. This Agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use.

- All controlled substances must come from the physician whose signature appears below or, during his absence from the covering physician, not the nurse practitioner.
- All controlled substances must be obtained at the same Pharmacy. Should the need arise to change pharmacies our office must be informed. If you do not inform the office at the time of your appointment refills will be sent to the pharmacy you have previously given us.

Pharmacy:_____
Phone:_____ Fax:_____

- The Prescribing Physician has permission to discuss all diagnostic and treatment details with the dispensing pharmacist or other professionals who provide your health care for purpose of maintaining accountability.
- You may not share, sell, or otherwise permit others including spouse or family members to have access to medications prescribed to you.
- Random urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may result in your discharge from the facility.
- Patient understands that he / she will not consume alcohol in conjunction with anxiety, sleeping aids, anti-depressants, etc. nor use, purchase or otherwise obtain any other legal or illegal drugs.
- Medications may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced, unless explicit proof is provided with direct evidence from the authorities. A report narrating what you reported to the authorities is not adequate. Additionally, it is the responsibility of the patient to provide such proof, which will not be a guarantee of prescription re-issuance.
- If the responsible legal authorities have questions concerning your treatment, as might occur, our confidentiality is waved and full access to our records of controlled substances administration will be given.

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CONTROLLED SUBSTANCE AGREEMENT (continued)

* Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone in for a prescription after hours, on weekends, or on holidays.
* If you need your medication(s) refilled please contact us, we will contact your pharmacy with the refilled prescription. Please allow 3-5 business days for refills to be processed.
* In the event you are arrested or incarcerate related to legal or illegal drugs, refills on controlled substances will not be given.
* It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician and may be discharged from the practice.
* You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand and accept all its' terms.

_____

Patient's full name (please print)

_____ _____

Patient's Signature Date

_____ _____

Physician's Signature Date

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OFFICE POLICIES

* **Medication Refills:** Please allow 3-5 business days for prescription refills to be processed. Controlled substance refills will not be processed on Fridays, please plan accordingly. Please do not use our after-hours emergency answering service to request refills.

* **Missed appointments / Untimely Cancellations:** A 24-hour notice is required for cancellation of appointments. A fee of $50.00 will be charged for those who cancel less than 24 hours or do not show up for their scheduled appointments.

* **Emergency on-call after hours service:** A charge of $50.00 will be applied to patient accounts if after hour calls placed are non-emergent in nature. Examples: Medication refills; appointment questions; any other questions that could have been addressed during scheduled appointment time.

****If there is a serious medical emergency, please call 911 or proceed to the nearest emergency hospital****

* **FMLA / Short term disability:** You must be a well- established patient before we will consider filling out documentation or requests for FMLA or short-term disability. This means you will need to develop a relationship with us including regularly attending your appointments, being compliant with all treatment, and be stable in treatment. If these items are met there will be a charge to complete the necessary documentation. You will be required to be in the office and submit payment before we can begin the documentation process.

* **Prior Authorization Policy:** At times your insurance company may decline payment for a medication that may help you. We can often work with your insurance company through a prior authorization procedure to get the medication covered. If we need to undertake this process, there will be a charge for the service that is not covered by insurance and will be paid prior to starting the process.

HIPPA (Health Insurance Portability and Accountability Act of 1996)

I acknowledge that I have received a copy of the privacy notice required in compliance with HIPPA. If I have any questions regarding HIPPA I acknowledge that I have asked for clarification and my questions have been answered to my satisfaction.

_____ _____

Patient's / Guardian's Signature Date

_____ _____

Witness Signature Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

Please print

Name:_____ SSN:_____ DOB:_____

I hereby give permission to: Dr. Dinar Sajan, M.D.
(Agency / Individual releasing information)
To disclose medical, including HIV, ARC any / or AIDS diagnosis _____(patient initials), psychiatric, psychological educational, alcohol and / or drug abuse information, or any other records of a sensitive nature, and may be released.

This information is to be released/obtained to/from: _____
(Agency / individual requesting information)

Street Address_____ City_____ State_____

Zip Code:_____ Phone:_____ Fax:_____

For the purpose of: Coordination of Care
The specific information to be disclosed is:

- ○ Psychiatric Information
- ○ Initial Assessment
- ○ HIV / AIDS
- ○ Progress Notes
- ○ Diagnosis
- ○ Labs / X-Ray / Test Result
- ○ Treatment
- ○ Drug / Alcohol Abuse and / or History
- ○ Other Specify:_____

I understand a general medical authorization or subpoena documents without specific authorization to release psychiatric / psychological information MUST have this waiver from the patient / client or empowered Representative. I understand that my records have a privileged and confidential status for the purpose contained within this authorization. I understand that I have the right to refuse to sign this authorization. My refusal will no way hinder me from receiving treatment. I understand this authorization may be revoked at any time upon written notification at the facility in which I received treatment, but revocation has no effect on action already taken as a result of this authorization. I understand that law prohibits any disclosure of this information by receiving agency, not by the Federal Privacy Law, but by the Federal and State Laws.

This authorization is for:
- ○ Singular use.
- ○ Continuing disclosure valid for 365 days after the date of my signature.

_____ _____
Signature of patient / client Date Signature of witness Date

_____ _____
Signature of legal guardian / representatives Date Relationship to patient

If a Patient / Client is a minor or unable to sign, legal representative / guardianship must be sustained with legal documentation accompanying this

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This notice describes how information about you may be used and disclosed and how you can gain access to this information.

Please review it carefully

NOTICE OF INFORMATION PRACTICES

1. THE PRACTICE may use and disclose protected health information for treatment, payment and healthcare operations. Example of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and / or referral to the other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers: and collection agencies. Healthcare operations includes, but is not limited to, internal quality control and assurance including auditing of records.
2. THE PRACTICE is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. THE PRACTICE will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. THE PRACTICE may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.
5. THE PRACTICE will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.
6. THE PRACTICE reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information of the patient. Copies may also be obtained at any time at our offices.
7. THE PRACTICE will provide each patient with a copy of any revisions of it's Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
8. Any person / patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the Headquarters address: 3919 Tampa Road - Oldsmar, FL. 34677. All Complaints will be addressed and results will be reported to the Corporate Compliance Officer.
9. It is THE PRACTICE'S policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
10. The name, title and telephone number of a person in the office to contact for further information Administrator, (727)733-6111.
11. The effective date of this Notice is March, 1st 2019.

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