Dr. Satish Narayan, M.D., P.A. & Dr. Nisha Satish, M.D., P.A.
Dr. Humaira Khalid, M.D.
Vivian Kisanga, PMHNP-BC

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

Patient Registration

PATIENT INFORMATION:

Last Name:______________________________First Name:__________________________Middle Initial: ______

Date of Birth:___________ Social Security #:______________________ Marital Status: Single/Married/Divorced/Widowed

Sex: Male [ ] Female [ ] Race:____________ Ethnicity:____________________Preferred Language: ___________

Mailing Address___________________________City:____________________State:_____________Zip:_______

Phone Number: Home________________________Cell____________________Work __________________

Employed: [ ] Yes [ ] No Full Time Student: [ ] Yes [ ] No Disabled: [ ] Yes [ ] No Retired: [ ] Yes [ ] No

Is the patient a minor? [ ] Yes [ ] No If Yes, Please fill out the information below:

Parent(s)/Guardian(s) Name: ____

Date of Birth: ____________________________Social Security #:______________________________________

Mailing Address___________________________City:____________________State:_____________Zip:_______

Phone Number: Home________________________Cell____________________Work __________________

May we contact you by phone for appointment reminders? [ ] Yes [ ] No Preferred Contact #: [ ] Home [ ] Work [ ] Cell

EMERGENCY CONTACT INFORMATION:

Spouse's Name: ____ Phone #:____________________

Name: ____________________________ Relationship: __________________ Phone #:____________________

Name: ____________________________ Relationship: __________________ Phone #:____________________

Primary Care Physician:____ Phone #:____________________

Specialist Physician: ____ Phone #:____________________

Specialist Physician: ____ Phone #:____________________

Counselor/Therapist: ____ Phone #:____________________

PATIENT EMPLOYER INFORMATION:

Name of Employer: ______________________________ Phone: ________________Fax: ___________________

Address: ________________________________City: __________________ State: ____________Zip: ________

INSURANCE POLICY INFORMATION:

Primary Insurance: _________________________Subscriber ID#: ______________________ Group#: __________

Policy Holder's Last Name: __________________________Policy Holder's First Name: __________________________

Policy Holder's Date of Birth: _______________________Policy Holder's Social Security #: _____________________

Relationship to the Patient: ____

Secondary Insurance: _______________________Subscriber ID#: ______________________ Group#: __________

Policy Holder's Last Name: __________________________Policy Holder's First Name: __________________________

Policy Holder's Date of Birth: _______________________Policy Holder's Social Security #: _____________________

Relationship to the 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

Dr. Satish Narayan, M.D., P.A. & Dr. Nisha Satish, M.D., P.A.
Dr. Humaira Khalid, M.D.
Vivian Kisanga, PMHNP-BC

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

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 ____________

Dr. Satish Narayan, M.D., P.A. & Dr. Nisha Satish, M.D., P.A.
Dr. Humaira Khalid, M.D.
Vivian Kisanga, PMHNP-BC

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

Medical and Behavioral Health History

Patient First Name:______________________Last Name:______________________DOB: __________
Why are you being seen today? ____

____

MEDICAL HISTORY Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Cancer (type) ________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):______________________________________

SURGERY HISTORY

Please list any surgeries you have had and the year they were done.

____

____

____

____

Do you have any medical problems that are not listed above?

____

____

Dr. Satish Narayan, M.D., P.A. & Dr. Nisha Satish, M.D., P.A.
Dr. Humaira Khalid, M.D.
Vivian Kisanga, PMHNP-BC

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

Patient First Name:________________________ Last Name:________________________ DOB: ____________
Why are you being seen today? ____

BEHAVIORAL HEALTH HISTORY — Do you now or have you ever had:

- ❑ ADHD/ADD (If Yes, at intake complete **ADHD Checklist**)
- ❑ Panic Disorder & Agoraphobia (If Yes, at intake complete **Panic & Agoraphobia** Scale)
- ❑ Alcohol Dependence
- ❑ Anorexia
- ❑ Borderline Personality Disorder
- ❑ Bulimia Nervosa
- ❑ Cannabis Dependence
- ❑ Delusional Disorder
- ❑ Bipolar and/or Mood Disorder (if Yes, at intake complete **The Mood Disorder Questionnaire**)
- ❑ Intellectual Disabilities
- ❑ Major Depressive Disorder (MDD) (If Yes, at intake complete **PHQ-9**)
- ❑ Nicotine Dependence
- ❑ Obsessive Compulsive Disorder (OCD) (If Yes, at intake complete **OCD/Y-Bocs Scale**)
- ❑ Social Anxiety/Social Phobia (If Yes, at intake complete **Social Interaction Anxiety**)
- ❑ Paranoid Schizophrenia
- ❑ Post-Traumatic Stress Disorder (PTSD)
- ❑ Schizoaffective Disorder
- ❑ Generalized Anxiety Disorder (GAD) (If Yes, at intake complete **GAD-7**)
- ❑ Sedative Dependence
- ❑ Pseudobulbar Affect (PBA) (If Yes, at intake complete **CNS-LS**)
- ❑ Substance Abuse
- ❑ Insomnia (If Yes, at intake complete **Insomnia Questionnaire**)
- ❑ DMDD

BEHAVIORAL HEALTH PRESCRIPTION HISTORY — Please select all of the following that you have tried and ***FAILED***:

Anti-depressants
- ❑ Prozac (fluoxetine)
- ❑ Zoloft (sertraline)
- ❑ Luvox (fluvoxamine)
- ❑ Paxil (paroxetine)
- ❑ Celexa (citalopram)
- ❑ Lexapro (escitalopram)
- ❑ Effexor (venlafaxine)
- ❑ Cymbalta (duloxetine)
- ❑ Wellbutrin (bupropion)
- ❑ Remeron (mirtazapine)
- ❑ Serzone (nefazodone)
- ❑ Anafranil (clomipramine)
- ❑ Pamelor (nortrptyline)
- ❑ Tofranil (imipramine)
- ❑ Trintellix (vortioxetine)
- ❑ Elavil (amitriptyline)

Mood Stabilizers
- ❑ Valproic Acid
- ❑ Tegretol (carbamazepine)
- ❑ Lithium
- ❑ Depakote (valproate)
- ❑ Lamictal (lamotrigine)
- ❑ Tegretol (carbamazepine)
- ❑ Topamax (topiramate)

Other medical medication (please list): ______________________________
____

Antipsychotics/Mood Stabilizers
- ❑ Seroquel (quetiapine)
- ❑ Zyprexa (olanzepine)
- ❑ Geodon (ziprasidone)
- ❑ Abilify (aripiprazole)
- ❑ Abilify Maintena Injection
- ❑ Aristada Injection
- ❑ Invega (paliperidone)
- ❑ Invega Sustenna Injection
- ❑ Invega Trinza Injection
- ❑ Clozaril (clozapine)
- ❑ Haldol (haloperidol)
- ❑ Prolixin (fluphenazine)
- ❑ Rexulti (brexpiprazole)
- ❑ Risperdal (risperidone)
- ❑ Saphris (asenapine)
- ❑ Vraylar (cariprazine)

Sedative/Hypnotics
- ❑ Ambien (zolpidem)
- ❑ Belsomra
- ❑ Lunesta (eszopiclone)
- ❑ Sonata (zaleplon)
- ❑ Rozerem (ramelteon)
- ❑ Restoril (temazepam)
- ❑ Desyrel (trazodone)

ADHD medications
- ❑ Adderall (amphetamine)
- ❑ Adderall XR (amphetamine XR)
- ❑ Concerta (methylphenidate)
- ❑ Evekeo (amphetamine)
- ❑ Focalin (dexmethylphenidate)
- ❑ Procentra (dextroamphetamine)
- ❑ Ritalin (methylphenidate)
- ❑ Strattera (atomoxetine)
- ❑ Vyvanse (lisdexamfetamine)
- ❑ Zenzedi (dextroamphetamine)

Anti-anxiety medications
- ❑ Xanax (alprazolam)
- ❑ Ativan (lorazepam)
- ❑ Klonopin (clonazepam)
- ❑ Valium (diazepam)
- ❑ Hydroxyzine
- ❑ Tranxene (clorazepate)
- ❑ Buspar (buspirone)

Substance/Alcohol Abuse
- ❑ Suboxone (buprenorphine/naloxone)
- ❑ Zubsolv (buprenorphine/naloxone)
- ❑ Bunavail (buprenorphine/naloxone)
- ❑ Subutex (buprenorphine)
- ❑ Vivitrol (naloxone) Injection
- ❑ Naloxone tablets
- ❑ Campral (acomprosate)
- ❑ Antause (disulfiram)

Dr. Satish Narayan, M.D., P.A. & Dr. Nisha Satish, M.D., P.A.
Dr. Humaira Khalid, M.D.
Vivian Kisanga, PMHNP-BC

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

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Children				
Grandparents				
Aunts/Uncles				

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling/staying asleep
- ❑ Poor appetite
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

Dr. Satish Narayan, M.D., P.A. & Dr. Nisha Satish, M.D., P.A.
Dr. Humaira Khalid, M.D.
Vivian Kisanga, PMHNP-BC

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

SUBSTANCE USE	Age when first tried this:	How much & how often did you use this?	How many years did you use this?	Last use?	Do you currently use this?
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, hashish, hash oil					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine (speed, ice, crank)					Yes □ No □
HEROIN					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaaludes					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OPIOIDS: Norco, Vicodin, Lorcet, Lortab, Methadone					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes □ No □

Hospitalizations

Have you been recently hospitalized or participated in any outpatient programs? [ ] Yes (Complete Below) [ ] No

When: ______________________ Where: ______________________ Reason: ______________________

Lab Work

Please indicate which lab you prefer or that is in network with your insurance for blood work and/or Urinary Drug Analysis.

☐

☐

☐ Other: ______________________

Drug Allergies

Please list any drug allergies and exactly how this medication affects you. (Examples: Rash, Hives, Itching, Swelling, etc.)

Medication Name: ______________________ Type of Reaction: ______________________

Medication Name: ______________________ Type of Reaction: ______________________

Pharmacy Information

Please list your pharmacy information. Please present a copy of your prescription card to the front desk.

Local Pharmacy Name: ______________________

City: ______________ Pharmacy Number: ______________ Fax Number: ______________

Mail Order Pharmacy: ______________________

City: ______________ State: ______________ Pharmacy Number: ______________ Fax Number: ______________

Dr. Satish Narayan, M.D., P.A. & Dr. Nisha Satish, M.D., P.A.
Dr. Humaira Khalid, M.D.
Vivian Kisanga, PMHNP-BC

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

Medication Consent Form

Please list ALL of the medications that you take below.

Medication Name, Strength and Directions	Anti-Depressant	Anti-Anxiety	Psycho-Stimulant	Mood Stabilizer	Neuroleptic	Sleep Aide	Anti-Craving	Other
1.	☐	☐	☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐	☐	☐	☐
5.	☐	☐	☐	☐	☐	☐	☐	☐
6.	☐	☐	☐	☐	☐	☐	☐	☐
7.	☐	☐	☐	☐	☐	☐	☐	☐
8.	☐	☐	☐	☐	☐	☐	☐	☐
9.	☐	☐	☐	☐	☐	☐	☐	☐
10.	☐	☐	☐	☐	☐	☐	☐	☐

Please stop here. The remainder of this form will be completed in your visit with the physician.

EDUCATIONAL METHODS USED – Check all that apply.

☐ Verbal Explanation, specify if only method available. ______________________

☐ Other Written Materials, specify. ______________________

☐ Side Effects; specify medication and associated side effect(s). ______________________

____

WOMEN OF CHILD BEARING YEARS ONLY – Check all that apply.

☐ I have been instructed in the safety of the above drugs in pregnancy. ______________________

☐ I have been informed of any above drug interaction which would interfere with the effectiveness of my birth control pill in current / future use, and the necessity to use alternate birth control measures. ______________________

____

☐ If pregnant of breast feeding, I agree to discuss with my obstetrician or pediatrician before starting the medication(s).

I ______________________ have been instructed in the medication benefits, alternatives, side effects, and precautions of the above listed medications. My questions and concerns about the prescribed medication have been addressed and I agree to inform my provider if other questions and / or concerns should arise.

______________________ ______________________
Patient/Guardian Printed Name Date/Time | Patient/Guardian Signature Date

______________________ ______________________
Nurse's Printed Name Date/Time | Nurse's Signature Date

______________________ ______________________
Provider's Printed Name Date/Time | Provider's Signature Date

Dr. Satish Narayan, M.D., P.A. & Dr. Nisha Satish, M.D., P.A.
Dr. Humaira Khalid, M.D.
Vivian Kisanga, PMHNP-BC

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

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 Printed Name ________________________ Patient Signature ________________________

Clinician's Printed Name ________________________ Clinician's Signature ________________________

Physician's Printed Name ________________________ Physician's Signature ________________________

Date: ________________________

Dr. Satish Narayan, M.D., P.A. & Dr. Nisha Satish, M.D., P.A.
Dr. Humaira Khalid, M.D.
Vivian Kisanga, PMHNP-BC

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

PsyMed Solutions Office Policies

Appointments: ___________ (Initial)

- Our office hours are 9:00 am to 5:00 pm Monday through Friday. Dr. Khalid has a limited amount of appointments every other Friday. Patient appointments are scheduling by calling during regular office hours. **CANCELLATION/NO SHOW FEES:** If your appointment is not canceled 24 hours in advance, our office will charge a rate of $50.00 per appointment that is NOT canceled and is payable prior to future visits. This fee will not be billed to the insurance company.
- Confirmation calls are made via an automated system at least two days prior to a scheduled appointment. It is the patient's responsibility to ensure PsyMed Solutions has the most current contact information on file.
- When a confirmation call is made and the patient does not answer the phone, a detailed voicemail will be left. If the voicemail is full or not setup, the patient will still be responsible if he/she does not come in for that appointment. Please remember that the confirmation call is a courtesy service provided by PsyMed Solutions.
- **PATIENT TARDY POLICY:** If the patient is more than 15 minutes late to their appointment, they will need to reschedule. We will no longer be working patients into the schedule. If there happens to be an opening in the schedule later that day, the patient may be re-scheduled to that time slot; otherwise, they will be rescheduled.

Financial Policy: __________ (Initial)

- An estimated payment is due at the time of service by cash, money order, Visa, MasterCard, Discover or American Express. Depending on the level of service provided, there may be an additional fee that is patient responsibility to pay within 30 days of receipt of your statement.
- Patients are responsible for their co-payments and/or deductibles and coinsurance at the time services are rendered for patients on Preferred Provider Plans (PPO's) or Health Maintenance Organizations (HMO's).
- Any balance on an account that is greater than 30 days old is considered past due.
- A statement will be mailed on a monthly basis and will reflect the current balance for all services rendered prior to the date on the statement. Payment is due upon receipt of statement.

Insurance: ________________ (Initial)

- Your insurance policy is a contract between you and your insurance company. While our billing professionals will do all they can to help our patients in communicating and negotiating with their insurance plan or other persons, we must inform patients that if you have any questions regarding coverage, benefits, or payment for services provided, it is the patients responsibility to contact the insurance carrier and resolve.
- In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered. If payment from your insurance carrier is not received within forty-five (45) days, we will seek payment in full from you. Balance of services that are delayed or denied by your insurance company due to Coordination of Benefits information will become your responsibility after thirty (30) days.
- I understand that if I have an HMO insurance plan, I might need a referral from my primary care physician through my insurance company with an authorization # before being seen. I understand that certain testing might need an authorization through my insurance company before being done, and I may not be able to get the test done the same day as my office visit until authorization is attained. I understand that I am responsible for all health insurance deductibles, copayments, and coinsurance charges not covered by my insurance policy. I understand that I will be responsible for charges not covered by my insurance policy that include, charges for services not medically necessary as determined by my insurance company. I understand and authorize in order for my claims to be processed that any policy holder of medical or other information about me be released to the social security and ministration and healthcare financing administration or its intermediaries, and any information needed for the claim. I permit a copy of this Authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits and other insurance companies apply. I understand that I am responsible for all cost not covered by my insurance.
- PsyMed Solutions and its employees do not guarantee that payment will be authorized for medical services; therefore, this office is not responsible for any adverse payment decisions or misuse of information.
- Notification of any change in your insurance status (i.e. new company, deductible, co-pay amounts, and coinsurance) must be provided to the office forty-eight (48) hours in advance of next visit or payment in full will be required.

Red Flag Policy: __________ (Initial)

- PsyMed Solutions must collect and store our patient's private medical, financial and personal identifying date. We must therefore be vigilant in protecting the patient information to which we have access to including medical, financial, and any other personal information contained in PsyMed Solutions medical, appointment, or billing records.
- You must present a valid state issued photo identification card prior to being seen at each appointment.
- If you would like us to bill your insurance carrier, you must present a valid insurance card prior to being seen at each appointment, or payment in full will be required.

Medical Records: __________________ (Initial)

- 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. Report preparation fees are based on the time involved.

Refill Requests/Messages: __________________ (Initial)

- All requests for prescription refills must be made during your office visit.
- Controlled Substance are not refilled without an appointment.
- Any phone messages left will be returned within 24 hours by the clinical staff and/or the physician if necessary.

Emergency Situations/After Office Hours: ___________ (Initial)

- We do not have an on-call or after hours emergency line. If you are having a medical emergency, please call 9-1-1 or go to the nearest emergency room, Carrollton Springs Hospital or Mesa Springs Hospital to be evaluated.

Dr. Satish Narayan, M.D., P.A. & Dr. Nisha Satish, M.D., P.A.
Dr. Humaira Khalid, M.D.
Vivian Kisanga, PMHNP-BC

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

Cellular Devices, cameras, camcorders or any other recording/photo taking devices are PROHIBITED: ___________ (Initial)

- To reduce the potential risk of a Federal HIPAA Violation, recording devices and/or photo taking devices are prohibited to include but are not limited to cell phones, camcorders and records.

REVIEW ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICES AND PRACTICES: _______________ (Initial)

- A COPY IS AVAILABLE IN PRINT UPON REQUEST

I have read and understand the Office Policy and I agree to accept responsibility as described above. I also understand the Office Policy may be amended or modified from time to time by the practice. I am expressing my understanding by initialing next to each item on this page as well as signing below. If you have any questions, please feel free to ask our staff for assistance. Thank you for allowing us to assist in your care.

Patient Name (Please Print)_______________________________________ Date_______________________

Signature of Patient or Guardian___________________________________ Relationship_________________

CONSENT TO APPOINTMENT DELAYS

We are pleased that you have partnered with Psymed Solutions & Aesthetics to assist you in addressing your health care needs. Because Dr. Narayan is a psychiatrist, he is at times required to respond to urgent situations outside of the clinic. If your appointment time is significantly delayed, you may reschedule your visit or elect to be treated by one of our other providers. We respect that your time is valuable. Please remember that appointments in our clinic are in high demand. We request that you set aside enough time on the day of your scheduled appointment in anticipation of delays. Your patience is appreciated and we will do everything we can to accommodate your schedule.

By signing this document, the patient and/or patient's guardian understands and agrees they have been advised that they may have an extended wait period for Dr. Narayan. The patient and/or patient's guardian also understands and agrees they have been given the option of scheduling with another provider in our clinic if the delay impedes on the patient's schedule. However, should the patient choose not to schedule with one of our other providers, the patient will be advised to find another provider outside Psymed Solutions & Aesthetics.

Patient Name (Please Print)_______________________________________ Date_______________________

Signature of Patient or Guardian___________________________________ Relationship_________________

NOTICE OF NO COVERAGE FOR INJECTIONS
EFFECTIVE: SEPTEMBER 1, 2016

Please be aware that your insurance company does not cover your injection. Please sign this form indicating that you understand it is not covered and that you will be responsible for $24 each time you have an injection. By signing below, the patient and/or patient's guardian acknowledges that he/she has read and understands the information regarding my benefits.

Patient Name (Please Print)_______________________________________ Date_______________________

Signature of Patient or Guardian___________________________________ Relationship_________________

NOTICE OF NO COVERAGE FOR URINE DRUG SCREENS
EFFECTIVE: FEBRUARY 3, 2017

Please be aware that your insurance company may not cover your urine drug screen, code G0477 or 80305. Please sign this form indicating that you understand it may not be covered and that you will be responsible for $12 if insurance denies payment. Thank you for your cooperation. By signing below, the patient and/or patient's guardian acknowledges that he/she has read and understands the information regarding my benefits.

Patient Name (Please Print)_______________________________________ Date_______________________

Signature of Patient or Guardian___________________________________ Relationship_________________