PERSONAL INFORMATION

PATIENT NAME: __________________________________SEX: □ M □ F DOB: _________ AGE ______Height.______ Weight_______

ADDRESS: ___________________________________ _______________ ______ SOCIAL SECURITY __ __ __. __ __. __ __ __ __
(CITY, STATE) (ZIP)

MARITAL STATUS: S M DIV SEP WID HOW DID YOU HEAR ABOUT OUR PRACTICE?__________________

PHONE: CELL: _______________ HOME: _________________WORK: _____________ OCCUPATION: _______________

Employer: ____

RESPONSIBLE PARTY/SPOUSE/ EMERGENCY CONTACT NAME: __________________ ________________ ________________ _
(Last) (First) (M.I)

RESPONSIBLE PARTY/ SPOUSE/ EMERGENCY CONTACT PHONE: _________________________

OCCUPATION __________________________EMPLOYER: _________________________SOCIAL SECURITY #: _________________

ADDRESS: __________________________________ ____________________ ____________________
(CITY, STATE) (ZIP)

E-Mail Address: ………..

INSURANCE INFORMATION

PRIMARY:
NAME OF PRIMARY INS:_______________________
NAME OF PRIMARY POLICY HOLDER __________________
DOB: ______________ POLICY ID# ___________________
GROUP #: __________

SECONDARY:
NAME OF SECONDARY INS:___________________
NAME OF SECONDARY POLICY HOLDER:
DOB ______________POLICY ID#: ________________
GROUP#_________

MEDICAL HISTORY (CONFIDENTIAL)

PSYCHIATRIC HISTORY: REASON FOR THIS VISIT, date of first mental illness, first diagnosis and a note of chronology

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PSYCHIATRIC MEDICATIONS

Medicine: ___________________________ DOSE: _________________ PRESENT/ PREVIOUS
Medicine: ___________________________ DOSE: _________________ PRESENT/ PREVIOUS
Medicine:___________________________ DOSE: _________________ PRESENT/ PREVIOUS
Medicine: ___________________________ DOSE: _________________ PRESENT/PREVIOUS

ALLERGIES

SELECT SYMPTOMS YOU HAVE OR HAVE HAD IN THE PAST YEAR

GENERAL

☐ Depression
☐ Dizziness
☐ Fainting
☐ Forgetfulness
☐ Headache
☐ Loss of sleep
☐ Loss of weight

CARDIOVASCULAR

☐ Chest pain
☐ High blood pressure
☐ Irregular heart-beat
☐ Low blood pressure
☐ Poor circulation
☐ PaceMaker
☐ CABG
☐ Stent
☐ High Cholesterol

NEUROLOGY

☐ Headache/Migraine
☐ CVA/Stroke
☐ Muscle Weakness
☐ Tremor/Shakiness
☐ Forgetfulness
☐ Seizure
☐ Sensory Loss
☐ Slurred Speech
☐ Tremor

SELECT CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST

☐ AIDS/HIV
☐ Alcoholism
☐ Anemia
☐ Anorexia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Breast Lump
☐ Bronchitis
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Hepatitis
☐ Ulcers
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headaches
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Cancer
☐ Pneumonia
☐ Prostate Problem
☐ Rheumatic Fever
☐ Bulimia
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Typhoid Fever
☐ Venereal Disease
☐ Vaginal Infections

SUBSTANCE ABUSE HISTORY (Past or current)

ALCOHOL: Y N PAINKILLER/ OPIOID/ HEROIN/MORPHINE: Y N TOBACCO: Y N
MARIJUANA: Y N COCAINE: Y N METHAMPHETAMINE: Y N LSD: Y N
ECSTASY: Y N OTHER ILLICIT/ RECREATIONAL DRUGS USED: ________________________

HIPAA

Consent to use and disclose your health information

This form is an agreement between you, ____And Silver Lining Psychiatry
(Print Your Name)
When we evaluate, diagnose and treat you we will be collecting PHI (Protected Health Information) about you. This information will be used to make a specific treatment plan unique to your needs. By signing this form you are providing consent to allow us to use your information related to your care and share with others per HIPAA guidelines as a covered entity. The Notice of Privacy Practices explains more in depth, your rights and how we can use and share your information. You may read this before signing this Consent form. You can retrieve a copy of the NPP from the receptionist. If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you. After you have signed this consent, you have the right to revoke it and we will conform with your wishes about using or sharing your information from that time on. (But any sharing that took place prior to your rescind cannot be redone).

_____________________ ___________________________________ ____
(PATIENT NAME) (DATE)

____ ___________________________________
(PATIENT/REPRESENTATIVE SIGNATURE) (RELATIONSHIP TO PATIENT)

“Financial and Office Policy” Contract

- Payment for services is your responsibility. We will not become involved in disputes between you and your insurance company regarding payments.
- Your deductible and copayment are due at the time of your visit. We accept cash and all major Credit Cards (Visa, Master, American Express, Discover, etc..)
- **We do not do any legal forms, employment related forms, FMLA, Short/Long term disability forms, School (semester) drop form. (we can provide excuse for the day of office visit)**
- **Providing a letter is solely upon practice discretion.** Practice reserves the right to decline to furnish such letters. Each case will be decided on an individual basis. We ask that you give us at least 3- 5 working days advance notice. **There will be a charge of $100-400 based on the type or nature of the letter.**
- In need of a medical record for any purpose, we provide a summary of your medical chart to your desired destination. That medical record document could be somewhere between 1-2 pages of typed up summary. We don’t share exact copies of medical records. **There will be a charge of $300 - $500 for that service based on the length and type of sharing.** There will be a 2 dollar charge per page for furnishing labs or other ancillary non clinical documents.
- You must call the office **48 business hours in advance for any appointment change or cancellation to avoid the $40 “NO SHOW” fee**. There will be a charge of $100 for new appointment cancellation less than 48 business hours. **A late arrival more than 15 min will be considered as no show**, which may incur the aforesaid charges outlined. Any such charge will be done by the office per office policy. The Practice will not notify you of such action orally or by mail
- ALL prescription refills may require up to 2 business days. The latest office visit must happen within 60 days. There will be a $40 refill charge. No prescription renewal will be called in during the weekends. Practice reserves the right to deny refill based on non-compliance and other factors per practice protocol.
- Accounts that are 90-120 days past due may be turned over for collection.
- Not all psychiatric conditions or therapy services are covered by some insurance plans. If your insurance does not pay for a particular service, you will be responsible for the payment in full.
- It is your responsibility to understand your plan's benefits. We only file with your primary insurance. It is the patient’s responsibility to file or claim any additional insurance
- **Any non-compliance with clinic policy/multiple or repeated phone calls/ verbal abuse/ threats/unprofessional behavior with office staff or providers will result in termination of care from this clinic**
- Your phone call will be returned within 3 business days based on the nature of the concern and prioritization by triage.
- Any question or concern will be directed to the providers via Medical Assistant/Front desk. Providers will communicate through the medical assistant/Front desk.
- This practice does not communicate through emails (except the document exchanges).
- **Please call us at least 48 business hours (2 business days) prior to your appointment if your insurance has changed. Not doing so can delay the verification process and you may be subject to the full visit fee payment.**
- There will be **NO REFILL** prescription for all **SCHEDULE MEDICATIONS** recipients for safety, compliance and minimization of other possible unlawful behavior. Those patients needed to be seen each Month (i.e. every 4 weeks).

I HAVE READ AND UNDERSTAND THE FINANCIAL CONTRACT STATED ABOVE.
I HEREBY PUT MY SIGNATURE AS AN APPROVAL WITHOUT ANY COERCE.

______________________	______________________	______________________
(PATIENT NAME)	(SIGNATURE)	(DATE)

CREDIT CARD PAYMENT CONSENT FORM

PATIENT NAME: ______________________ ________________________ _______________
(PRINT LAST) (FIRST) (MIDDLE INITIAL)

FULL NAME ON CARD: _____________________________________ CARD TYPE: Visa MC AMEX Disc

CARD NUMBER: _______________________________ ________EXPIRATION: ____ / 20______ CVV: _________
CARDHOLDER BILLING ADDRESS:

____ _____________________ ________ ________________
(STREET) (CITY) (STATE) (ZIP CODE)

I, ____hereby authorize Silver Lining Psychiatry without Border, scorp to charge my Card
(PRINT NAME)
For routine charges/fees, Refill charges, dues, copay, missed or last minute cancellation of visits per clinic policy. If I have questions about these charges, I agree to contact the practice via phone. I agree that I will not pursue a refund directly through my credit/debit company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay all penalty fee(s) incurred to my provider. I have read and understand the Credit Card Payment consent.

____
(CARDHOLDER SIGNATURE)

____
(DATE)

TREATMENT CONSENT FORM

AND PERMISSION TO PHONE REMINDER & LEAVE any MESSAGE

Providers: Dr. Sherin S. Parvez, MD | Dr. Saleh M. Parvez, MD. OR any other providers, offering services in collaborating practice

I (Patient/guardian) ____ do hereby voluntarily consent to evaluation and treatment by Silver Lining Without Borders, Corp (dba Silver Lining Psychiatry). I acknowledge that no guarantees have been made as to the result or outcome of diagnoses and treatment. I understand that some medication might cause adverse reactions/side effects. My provider will not be liable for any such untowards short or long term Adverse Effects/Side Effects or its consequences.I am aware that I am an active participant in the treatment /counseling process. I share responsibility for my treatment by being fully compliant. I hereby authorize the Providers (Physician/ARNP/ PAs/ /Therapist /Counselors assigned) to provide Psychiatric/Psychological care which includes Psychotropics Medications (Pills/capsules injections/Patch/Spray etc). I understand this practice is not obligated to receive or return any email/phone call after hours or during the weekends or holidays for any form of routine or emergency care. I would rather call 911 for any such emergencies. I give permission to this practice to communicate via phone (As the practice uses email to send or receive documents only). I agree to provide supportive documents if I am an adoptive parent, Custodial guardian or caregiver. I understand that all info provided by me is confidential. I also understand that it is my sole responsibility to maintain full compliance or as this treatment contract can be breached any time from either party for any reason.

I understand filling out this form or any phone screening done by the office is not a guarantee for having a schedule for the first visit. Again if I attend an Initial Evaluation (ie first visit w/ the Provider), it does not guarantee the continuation of care (ie any further follow up visits) at Silver Lining Psychiatry.

_____________________________ _____________ __________________________
Patient/Guardian Signature Date Witness Signature