GUPTA
Psychiatry

Date: _____ Referred by: _____

Name: _____ Preferred First Name: _____

Date of Birth: _____ Age: _____ Social Security: ____ - ___ - ____

Sex at Birth: □ Male □ Female How do you identify? □ Male □ Female □ other _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell phone #: _____ Home phone #: _____

Email address: _____

Authorization to Leave Messages and Receive Emails

I hereby authorize that phone messages, emails and/or text messages are allowed to be left at the above email address/ phone number(s) regarding my prescriptions, appointments and care.

Signature: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____ Insurance require 90 day? □ Yes □ No

Mail Order Pharmacy: _____
(This practice does not write 90 day prescriptions for controlled substances)

Insurance Provider: _____ Pharmacy Benefit Manager: _____

Policy Holder: □ Self □ Spouse □ Parent □ Other _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship to Patient: _____

HIPPA

I have been given a copy of the HIPPA privacy statement. I understand if would like a copy for my records, one will be provided to me.

I have read and understand the above statements: X_____

Gupta Psychiatry Policies and Agreements

Please read and sign the following information concerning the policies of this office. A copy of these policies will be available upon request.

Insurance/ Financial

1. Gupta Psychiatry will verify and file your mental health claims as a courtesy to you and we are willing to accept assignment of benefits. Gupta Psychiatry does not file Workman's Compensation, Medicare, Medicaid, or Secondary Insurance.
2. Please be aware that some of the services provided may be non-covered services, according to your insurance plan. You are responsible for the payment of services rendered, regardless of your insurance company's determination for necessity.
3. Co-pay/deductible amount asked for at the time of service is an estimate based on your insurance company.
4. If insurance has not made payment within 90 days, the bill is then the patient's responsibility.
5. As the owner of the insurance policy, you are responsible for verifying with your insurance company that you are eligible for mental health benefits and be aware of what portion you are responsible for. You are responsible for deductibles and non-covered services as determined by your insurance carrier.
6. If you can not pay for your visit on the date of service, your appointment will have to be rescheduled.
7. If we do not have a copy of your current insurance card, or if you have no insurance, payment is due at time of service**.**
8. Gupta Psychiatry accepts Cash, HSA/ FSA cards, Debit card and credit cards. (Visa, MasterCard and Discover)

I have read and understand the above statements: X_____

Labs

1. As the owner of the insurance policy, you are responsible for verifying which labs your insurance company is in network with and you should be aware what portion you are responsible for. You are responsible for deductibles and non-covered services as determined by your insurance carrier.
2. Labs and Genetic testing offered by this practice are not affiliated with Gupta Psychiatry and those services are billed by, and for a third party vendor. Gupta Psychiatry does not financially benefit from the use of these labs, they are offered as a courtesy to our patients. Patients may request to use a lab of their choice for services.
3. Urine drug screens that require confirmation will be sent to Mako Labs. If this lab does not work for you, you will be asked to go to Labcorp or Quest the day of the request to submit a urine sample for testing. Prescriptions will not be given until urine confirmation has been received (when applicable).

I have read and understand the above statements: X_____

Cancellations

1. Cancellation fees are not covered by insurance.
2. Appointments cancelled or rescheduled within 24 business hours of the appointment, will result in a $50.00 fee.
3. Appointments for which the patient does not show and no notice was given, will result in a $100.00 no-show fee.
4. Multiple appointment cancelations and/or no-shows could result in patient being dismissed from this practice.
5. Appointment reminder calls and emails are a courtesy we offer to our patients. As the patient, you are responsible for keeping up with your scheduled appointments.

I have read and understand the above statements: X_____

Medications

1. Prescription refill requests should be made through your pharmacy, by leaving a voice mail on the refill medication line, through Guptapsychiatry.com or by emailing refills@guptapsychiaty.com.
2. Please allow (3) business days to process all refill requests.
3. There is a $25.00 emergency refill fee. An emergency refill consists of replacing a hard copy of your prescription (Replacement can only happen once) and refills required due to missed appointments.
4. Refill requests made after 1pm on Fridays will be called in on the following business day.
5. Some insurance companies require Prior Authorization for medications to prove medical necessity. Gupta Psychiatry does Prior Authorizations as a courtesy to our patients at no charge. Please allow 7 business days for your insurance company to get back with us with an answer to whether or not they will cover your medication. As soon as we hear from your insurance company, you will be notified by this office.

I have read and understand the above statements: X_____

Paperwork/Letters

1. Gupta Psychiatry fills out paperwork for insurance and or disability as a courtesy to our patients and will be filled out on a first come first served basis. Please allow a minimum of 7 business days for all paperwork to be completed.
2. Requests for letters for any reason require provider approval and may require up to 7 business days to complete.
3. Disability paperwork WILL NOT be filled out for a patient after 1 visit.
4. Patients requiring short term disability will be required to attend IOP, PHP or another form of intensive therapy as indicated the provider.
5. Fees for paperwork and letters can not be filed to insurance and are the financial responsibility of the patient. FMLA paperwork is $25.00, Letters are $15.00 and all other paperwork is $25.00 per page.

I have read and understand the above statements: X_____

Use of Email

1. To help protect privacy, patient/clients are *strongly cautioned* against sending sensitive, detailed personal information to providers/assistants via Email.
2. Providers generally limit the use of Email communication to appointment scheduling notification and inquiries, and for providing general information about services. Use of Email for other, non-urgent information exchange may be negotiated between providers and patient/clients in some cases.

3. Copies of Email communications may, at the provider's discretion, be placed in patient/clients' confidential files whenever documentation of such communications is felt to be indicated and appropriate.
4. **Email *should not* be used to convey information of an urgent nature to providers.** Providers *cannot guarantee prompt responses to Email messages sent by patient/clients (or others) to providers.*
5. We will strive to respond within three business days to your email. If you have not heard back within that time, you should telephone the office and leave a message.
6. Email accounts provided by employers are the property of that company. All emails sent from that account may be accessible to people within that corporation. For the patient's best interest, do not e-mail this office from a work email.
7. Replies from your provider will usually come to the e-mail addresses from which you sent the original message. You should not expect to be able to initiate e-mail from one address and receive the reply at a different address.
8. If you share an e-mail account with family members, there is the possibility of revealing confidential information to others.
9. Most e-mail is *not encrypted*, and therefore not guaranteed to be private. Unauthorized access by outsiders is possible. Do not use e-mail for discussion of sensitive issues.

I have read and understand the above statements: X_____

Medication Agreement

The purpose of this agreement is to prevent misunderstandings about medications and the importance of following your prescribed treatment plan. Gupta Psychiatry has a "Zero Tolerance Policy" when treatment plans are given to patients and they are not fulfilled.
Please initial below and if you have any questions, please bring them up with your provider.

1. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.
2. I understand that if I break this Agreement, my doctor will stop prescribing medications and I will have to find another provider.
3. I will communicate fully with my doctor about the character and intensity of my symptoms, the effects on my daily life, and how well the medicine is working.
4. I will not use any illegal substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to a time when I am not driving, operating machinery and will be infrequent.
5. I will not share my medication with anyone.
6. I will not attempt to obtain any controlled stimulants or controlled anti-anxiety medications from any other doctor without consent of my provider at Gupta Psychiatry. If I am found to do so, I understand I will be dismissed from the practice.
7. I will safeguard my pain medication from loss or theft. I understand lost or stolen medications will not be replaced.
8. I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of controlled medications.
9. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
10. I authorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this sates Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medications. I authorize my doctor to provide a copy of this agreement to my pharmacy, primary care physician and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I have read and understand the above statements: X_____

Consent to Treatment

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Gupta Psychiatry. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of North Caroline Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling. I agree and consent to participate in psychiatric services offered by a provider at Gupta Psychiatry. I understand that I am consenting and agreeing to services provided within the scope of my provider's license, certification, and training or the scope of a provider's license, certification, and training that is directly supervised within the practice. I understand that I may see another provider within the practice if my provider is unavailable.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.
3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.
4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Gupta Psychiatry, and I consent to disclosure for use by Gupta Psychiatry staff for the purpose of continuity of my care. Per North Carolina mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.
5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.
6. **Expiration of Consent:** This consent to treat will only expire when I or Gupta Psychiatry terminates my care.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

I have read and understand the above statements: X_____