PATIENT REGISTRATION FORM

Patient Name: ______________________________ Social Security Number: ________-____-_______

Date of Birth: ______________ Sex: M/F/Choose Not To Answer Relationship Status: _____________

Address: ____

(Street) (City/State/Zip)

Phone Number: ___________________________ Email: ______________________________

Would you be interested in being contacted via phone, text, or email for appointment reminders and updates? YES/NO

Employer name: ___________________________ Employer Number: ___________________________

Employer Address: ____

(Street) (City/State/Zip)

Primary Care Physician: ___________________ How did you hear about us? __________________

PRIMARY INSURANCE

Provider: _________________ ID Number: _______________ Group Number: ____________________________

Policy Holder Name: _______________________ Policy Holder SS: _____-_____-_____ Policy Holder DOB: ___________

Effective Date: ____________

SECONDARY INSURANCE

Provider: _________________ ID Number: _______________ Group Number: ____________________________

Policy Holder Name: _______________________ Policy Holder SS: _____-_____-_____ Policy Holder DOB: ___________

Effective Date: ____________

EMERGENCY INFORMATION

Name:_______________________________ Address:______________________________

Phone Number: ___________________________ Relationship: __________________________

Please read and initial the following statements concerning our office policies:

_____ I certify that the information I have given on this form is true and correct to the best of my knowledge.

_____ I understand that if I arrive more than 10 minutes late for an appointment, it is not guaranteed that I will be seen. A $50.00 no show fee will be charged for this appointment if you are unable to be seen

_____ I understand that payment is required at the time services are rendered and I assume responsibility for this. I understand there is a $30.00 fee for all returned checks. *(Note to divorced parents: Payment is the responsibility of the parent that brings the child into the office for treatment regardless of the divorce decree. The divorce decree is a matter between the parents and the courts.)*

_____ I understand that insurance will only be filed with insurance companies that Frisco Mental Health Services and Dr. Rizvi is contracted with. In order to achieve this, please have all current insurance information on file. I understand that secondary insurance will not be filed.

_____ I understand that if there are any changes in my insurance coverage, I will notify the business office at least five (5) days prior to my next appointment or the visit will be self-pay or rescheduled.

_____ I understand that all information obtained regarding my insurance coverage is not a guarantee of payment by my insurance company. The amount collected at the time of the service is only as estimate. I understand that I am ultimately responsible for any and all balances on my account.

_____ I understand that it is my responsibility to keep track of my appointments. If I am unable to keep my appointment, I will notify the office at least 24 hours in advance. I understand that I will be charged $50.00 for the time reserved if I do not call and cancel or reschedule at least 24 hours prior to my scheduled appointment.

_____ I understand that regular office hours for Frisco Mental Health Services are Monday – Friday. 8:30 am – 5:00 pm.

_____ I understand that it is my responsibility to keep track of my medication supply. I understand that I should request refills during regular office hours and that requested outside regular business hours will not be called into the pharmacy until the next business day.

_____ I understand that my records are protected by special laws governing psychiatric/substance abuse records and that I must sign a “Release of Information” form before any records can be released.

I hereby authorize Furqan Rizvi, M.D. to provide psychiatric services to: ☐ me ☐ my child

Signature of Patient or Parent (If Patient is a minor) Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION

(INSURANCE CARRIER)

I do hereby consent and authorize Frisco Mental Health Services to release all information contained in my financial and medical records, including diagnoses ad test results, to my insurance company or health plan, their agents and independent contractors, or any other person or entity that is responsible for paying or processing payment for any portion of my bill, for the purposes of administration, billing and quality and risk management. This consent applies to all records created in the course of and relating to my treatment and for the purpose of reimbursement for treatment.

I understand that I my revoke this consent at any time by giving a written notice to Frisco Mental Health Services except to the extent that action has been taken in reliance thereon. If no prior notice of revocation is received, this consent will expire six (6) months after the date of patient discharge from treatment, unless another date or condition is specified.

Optional: Specified Date _______________________ or event/condition _________________________

I understand that I have the right to inspect and copy the information to be disclosed

I understand that if I refuse to consent to this Release of Information, the consequences will be that the insurance claim will not be filed.

Signature of Patient or Parent/Guardian   Date

Signature of Witness   Date

Notice to Receiving Agency/Person

This information has been disclosed to you from records protected by the Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosers of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains to or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug use patient.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my or my child's insurance company to pay directly to Frisco Mental Health Services, Furqan Rizvi, M.D. any insurance benefits otherwise payable to me or my child, if any by reason of the services described in the itemized statement rendered, and subject to the terms and limitations found in my insurance policy with the aforementioned company. THIS IS A DIRECT ASSIGNMENT OF RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed mu indebtedness to the above mentioned assigned, and I have agreed to pay in a current manner any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

Signature of Insured or Insured Representative Date

Signature of Patient or Parent/Guardian Date

Signature of Witness Date

FRISCO
MENTAL HEALTH SERVICES

ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES

Office Copy

YOUR RIGHTS:

- To be treated with dignity and addressed in a respectful manner
- Consistent, quality care by qualified and trained professionals in a clean and safe setting
- Humane care and treatment free of abuse, neglect, humiliation, threats or exploitation.
- Privacy of your treatment and your records.
- To be informed of risk, benefits, and alternatives to medications and/or therapy.
- To consult with another licensed practitioner at your own expense.
- To make a complaint or grievance.
- The same legal rights and responsibilities as all citizens, unless otherwise indicated by law.
- The right to be free from discrimination due to ace, color, religion, national origin, gender, disability, sexual orientation, or marital status.

YOUR RESPONSIBILITIES

- Please notify your provider immediately of any concerns, questions, or feedback you may have regarding your sessions and care.
- Keep appointment and when able to do so for any reason, **notify your therapist or physician's office with at least 24 hours' notice prior to your appointment. You will be charged $50.00 for appointment cancellations without 24 hours' notice.**
- To pay a fee of $15.00 for any medications if required on the same day
- To pay a fee of $30.00 for treatment reports you request on your behalf and/or for copied of your records.
- All copays, fees, or charges will be collected at the time of service. There is a $30.00 fee for all returned checks.
- To maintain a clean and safe office environment- avoid bringing any outside food or drinks into the clinic.
- Maintain a safe environment by not brining weapons, non-prescribed drugs, or alcohol to the premises of the clinic.
- Treat your provider, office staff and furnishings with respect and follow all posted office rules.
- Maintain supervision and responsibility for your children and family while at the office.
- Pay for any damages caused by carelessness, recklessness, or intention behavior of you or your family members.
- Provide accurate and complete information about current problems, past illnesses and treatment and other pertinent information.
- Inform us if you are receiving counseling, medications or other therapeutic services from another clinician.

- Participate in treatment decisions and follow the agreed upon plan or recommendations.
- Check with your therapist or physician's office about your appointment if inclement weather is forecasted
- You may be referred to another providing for failing to follow these responsibilities.

ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES

I acknowledge that I have reviewed and was given the opportunity to receive a copy of these RIGHTS AND RESPONSIBILITIES.

Printed Name of Patient Date

Signature of Patient or Parent/Guardian Date

NOTICE CONCERNING COMPLAINTS

Complaints may be reported to:

Texas State Board of Medical Examiners
ATTN: Investigations
1812 Centre Creek Drive Suite 300
P.O. Box 149134
Austin, TX 78714-9134

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered the opportunity to review and receive a copy of this Personal Health Information and notice of Privacy Practices which explains how my medical information will be used and disclosed

____

Printed Name of Patient Date

____

Signature of Patient or Parent/Guardian Date

____

Patient's Printed Name

1. I understand that the medication I am prescribed for ADHD is a Class II Narcotic and the medication I am prescribed for sleep, anxiety is a Class IV narcotic.
2. I understand that the medication cannot be refilled before thirty (30) days.
3. I understand that if I lose my prescription that I will have to wait until the last due date from the original due date the last prescription was written for a refill.
4. I understand the medication is for my use only and cannot be shared with anyone else.
5. I understand that I am subject to random drug testing.
6. I understand that I allow Dr. Rizvi to monitor my prescription data and history of practitioners at Texas Prescription Monitoring Program.
7. I understand that I will only the medication as prescribed.
8. I understand that I cannot take illegal street drugs with this medication and if illegal drugs are found in my system with drug testing this medication will not be renewed by my provider.

____

Patients Signature Date

PHARMACY INFORMATION

Pharmacy Name: ____

Pharmacy Address: ____

____

Pharmacy Phone Number: __________________________________

Patient Signature: ____