Welcome to Mid Cities Psychiatry!

Mid Cities Psychiatry

In the event of an emergency situation, go to your nearest emergency room or call 911

Our patient intake form takes approximately 35-40 minutes to complete. Completing this form is essential for us to provide the care you need and to schedule your appointment. If the form is not completed, we may be unable to assist you.

Practice Policy

Here are the expectations we set for patients at our clinic to ensure a safe environment, maintain a manageable workload for our team, and provide clear timelines for patient requests:

1. **Medications and Refill Requests**
   a) To request a refill your pharmacy must fax a refill request form to us at 855-295-2686 at least 4-5 business days before your medications end. Please allow at least 4 business days for refill requests to be completed.
      i. Business days at Mid Cities Psychiatry do not include weekends or holidays; therefore, refill requests will not be processed on these days. They will be processed on the next business day.
   b) Prescriptions for Schedule II controlled substances are strictly regulated and monitored by the Texas Prescription Program. A fee of $25.00 will be charged for requests made between office visits.
   c) If you lose your prescription or need a refill, it will be provided only after the provider's approval at your next scheduled appointment, and a $25.00 fee will apply. If you do not have an upcoming appointment, we will schedule one for you as soon as possible.
   d) Some medications require prior authorization from your pharmacy, which may take 4-5 business days depending on your insurance coverage.
   e) Patients who have not been seen by a provider in the last 60 days or more may be required to schedule a follow-up appointment before a refill request can be considered. This decision is the provider's discretion.
   f) Patients may be considered inactive if they have not been seen by a provider or have not been in contact with the provider for four months or more.
2. **Communication**
   a) Our administrative staff manages all appointment requests and correspondence. We strive to return your call within one business day.
   b) As a general guideline, please make effective use of your time with the provider.
      i. For any questions or concerns regarding billing charges or your account balance, please request the front desk to speak with our billing staff or Practice Manager.

Termination of Physician-Patient Relationship

a) It is the policy of Mid Cities Psychiatry to foster a cooperative and trusting physician-patient relationship. However, if this relationship fails to form or ceases to be mutually productive, termination may be considered under certain circumstances. These include, but are not limited to:
   i. Treatment/Follow-up Nonadherence: Failing to follow the prescribed treatment plan, abusing medications, tampering with prescriptions or documents, or repeatedly canceling or missing follow-up visits.
   ii. Verbal Abuse: Rude behavior or improper language by the patient, their family members, or friends towards office personnel, as well as exhibiting violent behavior, making threats of physical harm, or actions that threaten the safety and well-being of office personnel.
   iii. Distrust: Engaging in deceptive behaviors or lying.
   iv. Nonpayment: Failing to pay bills in accordance with our payment policy, accumulating unpaid bills without working with the office to establish a payment plan.

Guidelines for Continued Care

a) Your appointment is reserved exclusively for you, and it is your responsibility to keep it. As a courtesy, Mid Cities Psychiatry will send you three appointment reminders. We value both your time and our providers' time, which is why we do not overbook or double-book appointments.
b) Patients are entitled under federal law to access their medical records. We adhere to all applicable rules, guidelines, and exceptions to ensure compliance with patients' rights. Please allow at least four business days to process your request.
c) If you require a phone call or tele visit session with a provider, it will be billed at the standard office rate.
d) For completion of FMLA/STD/LTD or other forms, an appointment with a provider is necessary.
e) If medication has been continuously prescribed by the practitioner and you become an inactive patient, a maximum of one month of medication may be prescribed while you find an alternative healthcare provider.
f) Inactive status may be instituted after three missed appointments within the last 90 days.
g) If you (or your legal counsel) request, summon, or subpoena the participation or testimony of any Mid Cities Psychiatry team members for any legal proceedings, including trials or depositions, you must provide payment at the team member's hourly rate (three-hour minimum) or as restricted by law, 48 hours in advance of the participation. Mid Cities Psychiatry team members must be notified at least five business days prior to the event. Failure to provide timely notice or payment may result in Mid Cities

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Seema Kazi, MD, PA

Psychiatry seeking to quash the subpoena or refusing participation, and we may seek reimbursement from you for any legal fees incurred in obtaining court protection against such participation.

I have reviewed and understand Mid Cities Psychiatry's Practice Policy, and I agree to be bound by its terms. I also understand that Mid Cities Psychiatry reserves the right to modify its Practice Policy.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Payment / Balance / Cancellation / Rescheduling / No-Show Policy

Here are the expectations we set for patients at our clinic to ensure that both patient and provider time is respected and helps maintain the quality and timeliness of the healthcare services we provide:

1. Payment Obligations:
    a. Mid Cities Psychiatry is not obligated to provide services if you cannot pay copays, co-insurance, deductibles, or clear outstanding balances unless payment arrangements are made.
    b. In the event of financial difficulties, please contact us as soon as possible to discuss potential arrangements.
    c. If a payment is not received by the due date under a payment plan, a late fee of $25.00 will be charged. Future appointments may be canceled if a payment is missed.
    d. Upon a missed payment:
        i. Your full balance must be cleared before any future appointments can be scheduled.
        ii. Payment must be received within 21 days of the missed payment date, or your account may be referred to collections, and the physician-patient relationship may be terminated.
2. Cancellation, Rescheduling, and No-Show Fees:
    a. A fee will be automatically charged to your credit card on file for any appointment that is canceled or rescheduled within 24 business hours, or if you do not show up, as per the RCN Fee schedule.
    b. If you arrive more than 15 minutes late, you will not be seen, your appointment will be rescheduled, and your card will be charged according to the RCN fee schedule.
    c. These fees are nonrefundable. However, in cases of emergency, proof may allow for the charges to be discounted or waived at the next appointment.
    d. Missed appointments will be recorded in your file. Accumulating three no-shows within 90 days may lead to the termination of our physician-patient relationship, as outlined in our policies.
3. Cancellation / Rescheduling / No-Shows (RCN) Policy:
    a. Automatic charges apply per the RCN Fee schedule for cancellations or rescheduling with less than 24 business hours' notice or for no-shows. Arriving over 15 minutes late will also incur automatic charges.
    b. Cancellation / Rescheduling / No-Shows Limit per 90 days is maximum one (1).
4. RCN Fee Schedule:
    a. 40-minutes medication management appointment no-show fees: $150.00
    b. Psychologists' appointment no-show fees: $150.00 per hour
    c. Therapist appointment no-show fees: $150.00
    d. 20-minutes medication management appointment no-show fees: $75.00

Credit-Card Information

☐ Credit Card ☐ Debit Card

Name of Card Holder			
Card # (last 4 digits only)	XXXX-XXXX-XXXX-		
Card Expiration Date		Card Security Code	XXX

I, hereby authorize Mid Cities Psychiatry to debit my/our credit card account as per RCN Fee schedule anytime there's a canceled or rescheduled appointment within 24 business hours or in case of a no-show.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
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Seema Kazi, MD, PA

Mid Cities Psychiatry

Registration Form

Demographics

Full Name: _____ Date of Birth: _____ Social Security Number:_____

Height _____Weight_____

Please only fill the information on the following line if you are able to:

Temperature (Fahrenheit)_____ BP_____ Pulse_____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Gender Neutral ☐ Non-Binary ☐ Choose not to disclose

☐ Other: _____

Sexual Orientation: ☐ Asexual ☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Pansexual ☐ Choose not to disclose

☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Would not like to disclose

Race: ☐ American Indian or Alaska Native ☐Asian, Black or African American ☐Native Hawaiian or Other Pacific Islander ☐ White ☐ Other: _____

Reason for visit: _____

Email:_____ Home Phone Number: _____

Cell Phone Number:_____ Work Phone Number:_____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relation to Patient: _____

Emergency Contact's Primary Phone: _____ Alternate Phone Number: _____

Referral Source Name: _____ Preferred Language: _____

Are you Employed? ☐ Yes ☐ Disabled ☐ Retired ☐ Unemployed ***If yes, please answer the questions below about employment, otherwise please skip them.***

Type of Employment: ☐ Full Time ☐ Part Time

Company Name:_____ Occupation Name:_____

Have you served in the military? ☐ Yes ☐ No ***If yes, please answer the questions below about military service, otherwise please skip them.***

Which branch did you serve in? ☐ Army ☐ Guard ☐ Navy ☐ Reserves ☐Marines ☐ Coast Guard ☐ Air Force

How long did you serve?_____

What type of discharge did you receive? ☐ Honorable ☐ Dishonorable

If you answered Honorable:

Were you involved in any combat? ☐ Yes ☐ No ***If yes, please describe Combat experience:*** _____

_____

Are you troubled now by your military experience? ☐ Yes ☐ No ***If Yes, please describe:*** _____

_____

If you answered Dishonorable:

Please explain :_____

_____

Have you completed your education? ☐ Yes ☐ No ***If yes, please answer the questions below about education, otherwise please skip them.***

Highest Schooling: ☐ High School/GED ☐ Associates ☐ Bachelors ☐ Masters

Please provide a copy of an ID to the front desk for them to scan into your chart when you hand them this form.

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Self-Pay Or Insurance

Are you a self-pay? Yes ☐ | No ☐ <> If YES, please go to the next page, If NO, please continue

Primary Insurance Name _____ must attach primary insurance card

Secondary Insurance Name Yes ☐ | No ☐ _____
If YES, must attach secondary insurance card

Tertiary Insurance Name Yes ☐ | No ☐ _____
If YES, must attach tertiary insurance card

Medicare Patient
As per the policy of this clinic, Medicare patient is <u>required</u> to complete/sign "Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R131" last page of this Registration-Form.

_____ (please initial)

Patient Financial Policy

To minimize confusion and misunderstandings between our patients and practice, we have adopted the following financial policies. If you have any questions about these policies, please feel free to discuss them with us. We are committed to providing the best possible care and service, and consider your understanding of your financial responsibilities to be an essential part of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check (payable to Mid Cities Psychiatry), cash, debit card or credit card.

1. **Patient Insurance**
    a. We have established agreements with many insurers and health plans to accept an assignment of benefits. This means we will bill those plans with which we have an agreement, and you will only be required to pay the authorized co-payment at the time of service. It is our policy to collect this copayment when you arrive for your appointment.
    b. Your assistance may be needed to secure timely payment of your claims. If your health plan mandates that you obtain prior authorization in the form of a referral from your primary care physician, or precertification before procedures or treatment plans can be initiated, please inform our staff in advance so that we can ensure these requirements are met.
    c. If you are insured by a plan with which we do not have an agreement, we will prepare and send claims on your behalf. However, you should be aware that your share of the medical fees may be higher when using non-contracted physicians compared to contracted ones.
    d. Please be aware that not all services may be covered under your insurance plan, and certain services might be excluded. If your insurance determines a service is "not covered," you will be responsible for the full cost. Any amount designated as your responsibility must be paid upon receiving a statement from our office..
    e. We will bill your health plan for all services provided at Mid Cities Psychiatry. Any balance due is your responsibility and should be paid upon receipt of a statement from our office or from your insurance.
2. **Insurance Claim Processing and Payment Responsibilities**
    a. Please do not presume that your insurance carrier is actively processing your claim. If you have not received notification of payment within 30 to 45 days following your treatment, it is important to contact your insurance provider directly. Should there be a delay in payment, we kindly request that you engage with your insurance or health benefits office to resolve any pending issues. In the event that your insurance company denies payment, citing that the services rendered by Mid Cities Psychiatry are not medically necessary, this consent grants Mid Cities Psychiatry the authority to seek payment directly from you for those services. Ultimately, you will be responsible for any services not reimbursed by your insurance.
3. **Patients who are Minors**
    a. For all services provided to minor patients, we will seek payment from the adult accompanying the patient, or from the parent or guardian who has custody.

By my signature below, I acknowledge and understand that it is ultimately my responsibility and obligation to be aware of my insurance's requirements, coverages, deductibles and payments.

I have read and understand the policies of the practice, and I agree to be bound by its' terms. I also understand and agree that the practice may amend such terms from time to time.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

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Seema Kazi, MD, PA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedure will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigation, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail / texts and/or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information

The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive a printed copy of this notice

Practice Duties

Law requires us law to maintain privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact us to let us know. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

_____
(please initial)

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Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

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My Authorization to Release All Healthcare Information Including Mental Health

I hereby authorize the following person (s) to be involved with and receive information pertaining to my medical care including mental health. I understand that any and all information can only be given in person, and after presenting a picture ID.

I understand and agree that I have the right to revoke this authorization anytime by sending/giving a written notice to Mid Cities Psychiatry. And until I revoke this authorization in writing, this authorization is valid indefinitely.

Name	Address	Phone/Fax

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Main Office Location

Mid Cities Psychiatry

200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
www.MidCitiesPsychiatry.com

My Authorization to Release All Healthcare Information Including Mental Health

To

Seema Kazi, MD dba Mid Cities Psychiatry

This is a release form for authorization of your medical information to be transferred between health care providers, health insurance companies and any other party involved in your medical care.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Social Security #	

I authorize the following facilities/hospitals and doctor(s) to release all medical information to Seema Kazi, MD dba Mid Cities Psychiatry for treatment consultation and to better manage my health.

This request includes: hospital summaries, echocardiogram reports, cardiac catheterization reports, laboratory reports, electrocardiograms, physician progress notes, labs, and any other healthcare information relating to my condition including my mental health progress notes.

I understand and agree that I have the right to revoke this authorization anytime by sending/giving a written notice to Mid Cities Psychiatry. And until I revoke this authorization in writing, this authorization is valid indefinitely.

List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:

Name	Address	Phone/Fax

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Mid Cities Psychiatry

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. See below below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. See below below.

D. For any mental/Behavior Health services	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. See above listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D. See above listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D. See above listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D. See above listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Patient Communication Consent Form

From time to time, we may need to communicate with you and to preserve your privacy, we would like for you to indicate your preferred method for us to communicate with you. Examples of such information to be communicated include appointment dates, appointment reminders, appointment follow-up, test results, billing questions, and other information clinical in nature.

If no one is available to answer your phone, we request your permission to leave certain types of information on your answering machine, voicemail, or email. Please fill out the following and then indicate your preference by checking Yes □ / No □ of the boxes below;

I give permission to Mid Cities Psychiatry personnel to leave the following forms of information pertaining to me on answering machine, voicemail or e-mails listed below.

Communication Type	Cell #	Home #	E-mail
Appointment Date & Time Reminders	Yes □ / No □	Yes □ / No □	Yes □ / No □
Appointment Follow-Ups	Yes □ / No □	Yes □ / No □	Yes □ / No □
Test Results	Yes □ / No □	Yes □ / No □	Yes □ / No □
Clinical Information	Yes □ / No □	Yes □ / No □	Yes □ / No □
Billing Questions	Yes □ / No □	Yes □ / No □	Yes □ / No □

This consent may be revoked at any time through written notification, except to the extent that action has already been taken based on this consent.

Share Your Experience with Us

Our number one priority is your satisfaction. Reviews are an important part of our practice, and we value your feedback. After your appointment, we will send you a text message inviting you to share your experience with us. Please note that only your first name and last initial will be displayed on your review. Your email will not appear on the review, and we will never share it with third parties

1. RISK OF USING EMAIL

Transmitting patient information via email entails several risks that patients should consider before utilizing this form of communication. These risks include, but are not limited to:

a) Circulation and Storage: Email can be circulated, forwarded, stored electronically and on paper, and inadvertently broadcast to unintended recipients.

b) Misaddressing**: It is easy to misaddress an email, which could result in information being sent to the wrong recipient.

c) Backup Copies: Backup copies of emails may exist even after the sender, or the recipient has deleted their respective copies.

d) Inspection by Third Parties: Employers and online services have the right to inspect emails transmitted through their systems.

e) Security Breaches: Email can be intercepted, altered, forwarded, or used without authorization or detection.

f) Viruses: Email can serve as a medium for introducing viruses into computer systems.

g) Legal Evidence: Emails can be used as evidence in court proceedings.

h) Lack of Security: Emails may not be secure, which could potentially lead to a breach of confidentiality by third parties.

2. CONDITIONS FOR THE USE OF EMAIL

Providers will strive to maintain the security and confidentiality of email communications but cannot guarantee this. Providers are not liable for improper disclosure of confidential information unless it results from the Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions regarding the use of email communications:

a) Emergency Use: Email should not be used for urgent or emergency situations. Providers cannot guarantee prompt review or response times for emails.

b) Email Content: Emails should be concise. Patients are advised to schedule an appointment for issues that are too complex or sensitive to be addressed via email.

c) Record Keeping: Emails will generally be printed and filed in the patient's medical record.

d) Access by Office Staff: Office staff may read emails addressed to providers.
e) External Communication: Providers will not forward emails that contain patient identifiable information outside of Mid Cities Psychiatry without the patient's written consent, except as required or permitted by law.
f) Sensitive Information: Patients should avoid using email for communication about sensitive medical information.
g) Liability for Breaches: Providers are not liable for breaches of confidentiality caused by the patient or any third party.
h) Patient Responsibility: It is the patient's responsibility to follow up or schedule an appointment if necessary, based on email communications.

3. INSTRUCTIONS
To ensure effective and secure email communication, patients are expected to adhere to the following guidelines:
a) Employer's Computer: Avoid using an employer's computer to send or receive emails, as employers may have the right to access such communications.
b) Patient Identification: Include your name in the body of the email to verify your identity.
c) Subject Line**: Clearly indicate the purpose of your email (e.g., medical question, billing question) in the subject line to facilitate timely and appropriate responses.
d) Email Address Updates: Inform your Provider of any changes to your email address to ensure ongoing communication.
e) Email Acknowledgment: Acknowledge any emails received from the Provider to confirm that the message has been read and understood.
f) Confidentiality Precautions: Take appropriate precautions to maintain the confidentiality of email communications, such as using secure networks and avoiding public Wi-Fi when communicating sensitive information.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with my treating physician or the Mid Cities Psychiatry Privacy Officer

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Medication Acknowledgement for Psychiatric Prescriptions

By signing this agreement, I, _____ I agree to the following:
(patient's printed name)

1. **Scheduled Appointments:** To see my psychiatrist as scheduled for Psychiatric Prescription management.
2. **Urine Drug Screen:** To provide a urine sample upon request for a Urine Drug Screen, either at the office of Mid Cities Psychiatry or through an accredited laboratory within 48 hours of Mid Cities Psychiatry's request. Should the Urine Drug Screen result be (1) positive for substances not prescribed or (2) negative for medications prescribed by a medical professional engaged in my care and treatment, Mid Cities Psychiatry reserves the right to decline any further psychiatric prescriptions.
3. **Payment of Fees:** To pay all office fees at the time of my visits before any service or prescription is rendered.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

<><><>

Medication Acknowledgement for ADD

By signing this agreement, I, _____ I agree to the following:
(patient's printed name)

1. **Monthly Psychiatrist Visits:** To see my psychiatrist every month to maintain my prescription for ADD medication.
2. **Urine Drug Screen:** To provide a urine sample upon request for a Urine Drug Screen, either at the office of Mid Cities Psychiatry or through an accredited laboratory within 48 hours of Mid Cities Psychiatry's request. If the Urine Drug Screen results in (1) a positive test for substances not prescribed or (2) a negative test for medications prescribed by a medical professional engaged in my care, Mid Cities Psychiatry reserves the right to decline any further ADD prescriptions.
3. **Annual EKG:** To have an EKG performed annually by my primary care physician specifically for my ADD medication and to ensure that the results are sent to or faxed to Mid Cities Psychiatry.
4. **Yearly Physical Examination:** To undergo a physical examination annually by my Primary Care Physician to monitor health suitability for continued ADD medication.
5. **Payment of Fees:** To pay all office fees at the time of my visits before any services or prescriptions are rendered.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

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Seema Kazi, MD, PA

Medication Acknowledgement for Opiate Management

I, _____ requesting that my doctor provide buprenorphine treatment for opioid

_____ addiction. By signing this agreement, I agree freely and voluntarily to accept

this treatment as follows:

1. **Appointment Commitment:** I will keep all scheduled appointments with the provider and their assistant and arrive on time.
2. **Conduct:** I will conduct myself courteously in the physician's office or clinic.
3. **Urine Drug Screen:** I will provide a urine sample upon request for a Urine Drug Screen, either at the office of Mid Cities Psychiatry or through an accredited laboratory within 48 hours of the request. If the Urine Drug Screen is (1) positive for substances not prescribed or (2) negative for medications prescribed by a medical professional engaged in my care and treatment, Mid Cities Psychiatry has the right to decline any further psychiatric prescriptions.
4. **Payment of Fees:** I will pay all office fees at the time of my visits before any service or prescription is rendered.
5. **Substance-Free Requirement:** I will not arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me, and I will not be given any medication until my next scheduled appointment.
6. **Medication Security:** I will not sell, share, or give any of my medication to another person. I understand that mishandling my medication is a serious violation of this agreement and will result in termination of my treatment without recourse for appeal.
7. **Medication Safety:** I understand that using buprenorphine/naloxone (Suboxone) if addicted to opioids could cause severe withdrawal symptoms, and stopping buprenorphine could also cause opiate withdrawals.
8. **Behavioral Expectations:** I will not deal, steal, or engage in illegal or disruptive activities in or around the doctor's office.
9. **Medication Dispensation:** My medication (or prescriptions) will only be given during regular office visits. If I miss an appointment, I will not receive medication until the next scheduled visit.
10. **Responsibility for Medication:** I will keep my medication in a safe and secure place. I agree that lost medication will not be replaced, regardless of the circumstances.
11. **Medication Sources:** I will not obtain medications from any other physicians, pharmacists, or other sources without informing my treating physician. I am aware that mixing buprenorphine with other medications, especially benzodiazepines or alcohol, can be hazardous and potentially fatal.
12. **Adherence to Treatment:** I will take my medication exactly as prescribed by the doctor and their assistant and will not alter my medication regimen without consulting the doctor first.
13. **Comprehensive Treatment Participation:** I acknowledge that medication alone is not sufficient treatment for my condition and agree to participate in the recommended patient education and relapse prevention programs.
14. **Treatment Compliance:** I understand that my buprenorphine treatment may be discontinued, and I may be discharged from the clinic if I violate any terms of this agreement.
15. **Treatment Alternatives:** I am aware of the alternatives to buprenorphine treatment for opioid addiction, which include medical withdrawal and drug-free treatment, naltrexone treatment, and methadone treatment.

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Patient Health Questionnaire (PHQ-9)

Please select each appropriate answer in the question as to over the last 2 weeks, how often have you been bothered by any of the following problems?
Use the following scale to choose the most appropriate number for each situation….

#s	Questions	frequency			
		Not At All	Several Days	More Than Half of the Days	Nearly Every Day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	Add Columns…….				
	Your PHQ-9 Scale Total Score Is….				

If you checked off any of the problems,
how difficult have these problems made it for you to do your work,
take care of things at home,
or get along with other people?

Not difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	

Mid Cities Psychiatry provides;

- Transcranial Magnetic Stimulation (TMS), a non-invasive and has minimal side effects, suitable for those preferring a non-drug approach.
- Esketamine offers rapid relief for severe, treatment-resistant depression
- Ketamine is used for its quick effects and potential long-term benefits to brain function.

The choice between these treatments depends on the patient's specific medical needs, severity of depression, and personal preferences. This decision is typically made by your provider, who evaluates all relevant factors.
Patient agrees to be contacted by a Patient Navigator Advocate to know more about these treatments.

_____ Yes _____ No

_____ Name of Patient _____ Date of Birth

_____ Signature of Patient or Responsible Party (if minor Patient) _____ Date

_____ Signature of Patient Representative (If Applicable) _____ Date

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CSSRS Screening

If you marked 1, 2, or 3 on question #9 of the PHQ-9, please complete the CSSRS screening. Otherwise, skip this section please.

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES, ask: ***Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

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Homicidal Ideations

Are you having Homicidal Ideations? ☐ Yes ☐ Yes and I am afraid I may act on them ☐ No

If you answered Yes or Yes and I am afraid I may act on them: Do You Have a Plan? ☐ Yes ☐ No

If you answered Yes: What is your plan? _____

Possession of Gun

Do you own a gun? ☐ Yes ☐ No

Rapid Mood Screener (RMS)

Are you among the millions of people who have depressive symptoms? Answer the following questionnaire about your medical history and provide it to your doctor or nurse to assist in an important conversation about your mood.

Please select one response for each question. You can complete the **RMS** in less than 2 minutes.

Patient Name _____ Date _____

	YES	NO
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	☐	☐
2. Did you have problems with depression before the age of 18?	☐	☐
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	☐	☐
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	☐	☐
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	☐	☐
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	☐	☐

Generalized Anxiety Disorder Questionnaire (GAD-7)

Please select each appropriate answer in the question as to over the last 2 weeks, how often have you been bothered by any of the following problems?

Use the following scale to choose the most appropriate number for each situation….

#s	Questions	frequency			
		Not At All	Several Days	More Than Half of the Days	Nearly Every Day
1	Feeling nervous, anxious or on edge?	0	1	2	3
2	Not being able to stop or control worrying?	0	1	2	3
3	Worrying too much about different things?	0	1	2	3
4	Trouble relaxing?	0	1	2	3
5	Being so restless that it is hard to sit still?	0	1	2	3
6	Becoming easily annoyed or irritable?	0	1	2	3
7	Feeling afraid as if something awful might happen?	0	1	2	3
	Add Columns…….				
	Your GAD Scale Total Score Is….				

Anxiety level based on score is;	no Anxiety (0-4)	mild (5-9)	moderate (10-14)	severe (15-21)

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Over the past six months, have any problems with attention, focus, or time management impacted your personal or professional life? ☐ Yes ☐ No
If yes, please complete the ASRS-v1.1 form below. If no, you may skip it..

Adult ADHD Self-Report Scale Symptom Checklist (ASRS-v1.1)

Name of Patient _____ Today's Date _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very often
Part A					
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
Part B					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn-taking is required?					
18. How often do you interrupt others when they are busy?					

Do you think that you have any learning disabilities? ☐ Yes ☐ No

Would you like to conduct a learning assessment at Mid Cities Psychiatry? ☐ Yes ☐ No

Current Providers

Primary Care Provider

Do you have a Primary Care Physician? ☐ Yes ☐ No ***If yes, then please fill 1-4, if No then please skip to number 4.***

1. Who is your Primary Care Provider?
2. When was your last visit to your Primary Care Provider?
3. When was your last Health & Physical?
4. Do you need help finding a Primary Care Provider? ☐ Yes ☐ No

Psychotherapist

Do you have a Psychotherapist? ☐ Yes ☐ No ***If yes, then please fill questions 1-3, if No then please skip to number 3.***

1. Who is your Psychotherapist?
2. When was your last visit to your Psychotherapist?
3. Would you be interested in exploring Psychotherapy services at Mid Cities Psychiatry? ☐ Yes ☐ No

Psychologist

Do you have a Psychologist? ☐ Yes ☐ No ***If yes, then please fill questions 1-3, if No then please skip to number 3***

1. Who is your Psychotherapist?
2. When was your last visit to your Psychologist?
3. Would you be interested in exploring Psychology services at Mid Cities Psychiatry? ☐ Yes ☐ No

Current Medical State - Stressors

Do you have Current Stressors? ☐ Yes ☐ No

If yes, please describe

Treatment Goal

What is your short-term treatment goal?

What is your long-term treatment goal?

Symptoms

Do you have Current Symptoms? ☐ Yes ☐ No

If yes, please describe

Physical Pain

Have you had physical pain in the last week? ☐ Yes ☐ No

If yes, then please fill question 1, if No then please skip question 1.

1. On a scale of 0 to 10, how bad was your pain (0 = no pain, 10 = severe pain)?

Do you have physical pain now? ☐ Yes ☐ No

If yes, then please fill question 2, if No then please skip question 2

2. On a scale of 0 to 10, how bad is your pain (0 = no pain, 10 = severe pain)?

Nutritional Status

1. Do you have food allergies? ☐ Yes ☐ No
2. Have you had weight loss or gain of 10 pounds or more in the last 3 months? ☐ Yes ☐ No
3. Have you had a decrease in food intake and/or appetite? ☐ Yes ☐ No
4. Do you have dental problems? ☐ Yes ☐ No
5. Do you engage in behaviors like binging or inducing vomiting? ☐ Yes ☐ No

Medical History

Have you had any medical diagnoses (seizures disorders, diabetes, heart problems, other)? ☐ Yes ☐ No

If yes, then please fill questions 1-3, if No then please skip this section

1. Please list any medical diagnoses you have had

2. What was the date of each diagnosis?

3. Who was the provider for each diagnosis?

Surgical History

Have you had any surgeries in the past? ☐ Yes ☐ No

If yes, then please fill questions 1-3, if No then please skip this section

1. What procedure(s) did you have?

2. When was the date of each procedure?

3. Who was the provider for each procedure?

Family Medical History

Do you have biological family members with a medical history of seizures, disorders, diabetes, heart problems, or other conditions? ☐ Yes ☐ No

For each affected family member, please provide the following information: your relationship to them, whether they are alive, their age of onset for the condition, and their diagnosis.

Relationship	Alive (Yes/No)	Age of Onset	Diagnosis

Psychiatric History <> Psychiatric Diagnoses

Have you been diagnosed with any psychiatric disorders? ☐ Yes ☐ No

If yes, then please fill questions 1-3, if No then please skip this section

1. Please list any psychiatric diagnoses you have had:

2. What was the date of each diagnosis?

3. Who was the provider for each diagnosis?

Psychiatric Hospitalizations and/or Rehabilitation

Have you been hospitalized with psychiatric disorders and/or attended rehabilitation facilities? ☐ Yes ☐ No

If yes, then please fill questions 1-2, if No then please skip this section

1. What is the name of the hospital or rehabilitation facility?

2. When were you hospitalized or attended the rehabilitation facility?

Family Psychiatric History

Do you have any biological family members with psychiatric history? ☐ Yes ☐ No

For each affected family member, please provide the following information: your relationship to them, whether they are alive, their age of onset for the condition, and their diagnosis.

Relationship	Alive (Yes/No)	Age of Onset	Psychiatric History

Trauma, Abuse, Neglect, and Exploitation

Have you experienced any trauma, abuse, neglect, or exploitation? ☐ Yes ☐ No

If yes, then please fill question 1, if No then please skip this section

1. What have you experienced**?** ☐ Trauma ☐ Abuse ☐ Neglect ☐ Exploitation

Please Explain

Nicotine

Do you use nicotine products? ☐ Yes ☐ No

If yes, then please fill questions 1-5, if No then please skip this section

1. What type of nicotine products do you use?

2. What is your current pattern of use?

3. What was the peak frequency of your usage for each usage? ☐ Continuous ☐ Episodic ☐ Binge

4. What age did you start using

5. What age did you stop using?

To help us assess all aspects of your health, we include a standard evaluation for alcohol use.
Do you drink alcohol? ☐ Yes ☐ No
If you answered 'Yes', please fill out the AUDIT (Alcohol Use Disorders Identification Test) below to help us understand your drinking patterns better.
If you answered 'No', please feel free to skip this section.

Alcohol Screening Questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 Times a Month	2-3 Times a Week	4 or more Times a Week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M	0-4	5-14	15-19	20+
W	0-3	4-12	13-19	20+

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Previous Substance Use

Were you involved in Substance Use? ☐ Yes ☐ No

If yes, then please fill questions 1-6, if No then please skip this section.

1. What were the names of the substance(s)?

2. . How did you acquire these substance(s)?

3. What was the peak frequency of your usage for each substance? ☐ Continuous ☐ Episodic ☐ Binge

4. What route was the substance taken?

5. What age did you start using?

6. What age did you stop using?

Current Substance Use

Are you currently involved in Substance Use? ☐ Yes ☐ No

If yes, then please fill questions 1-6, if No then please skip this section.

1. What were the names of the substance(s)?

2. . How did you acquire these substance(s)?

3. What is your current pattern of use?

4. What is the peak frequency of your usage for each substance? ☐ Continuous ☐ Episodic ☐ Binge

5. What route are the substance(s) taken?

6. What age did you start using?

Psychiatric Medications

Have you previously been prescribed any Psychiatric Medications? ☐ Yes ☐ No

If yes, then please fill question 1-5, if No then please skip this section

1. What were the names of the medication(s)?

2. What were the doses of the medication(s)?

3. When did you start taking the medication(s)?

4. When did you stop taking the medication(s)?

5. What side effects did you experience from the medication(s)?

Non-Psychiatric Medications

Have you previously been prescribed any Non-Psychiatric Medications? ☐ Yes ☐ No

If yes, then please fill question 1-5, if No then please skip this section

1. What were the names of the medication(s)?

2. What were the doses of the medication(s)?

3. When did you start taking the medication(s)?

4. When did you stop taking the medication(s)?

5. What side effects did you experience from the medication(s)?

Medication Allergies

Do you have any Medication Allergies? ☐ Yes ☐ No

If yes, then please fill question 1-2, if No then please skip this section.

1. What is the name of the medication(s) you are allergic to?

2. What were the reaction(s) you experienced?

Pharmacy

Do you have Pharmac(ies)? ☐ Yes ☐ No

If yes, then please fill question 1-4, if No then please skip this section

1. What are the names of the pharmac(ies)?

2. In which cities are the pharmac(ies) located?

3. In which state(s) are the pharmac(ies) located?

4. What are the phone numbers of the pharmac(ies)?

Legal History

Convictions

Do you have a Current or Previous Conviction? ☐ Yes ☐ No

If yes, then please fill question 1-4, if No then please skip this section.

1. What were the arrest date(s)?

2. What were the charge(s)?

3. Were you convicted?

4. What were the sentence(s)?

Probation

Are you currently on Probation? ☐ Yes ☐ No

If yes, then please fill question 1-2, if No then please skip this section.

1. Are you also on parole?

2. What is the ending date of your probation?

Lawsuits

Are you involved in any lawsuits? ☐ Yes ☐ No

If yes, then please explain below, if No then please skip this section.

Court Dates

Do you have any upcoming Court Dates? ☐ Yes ☐ No

If yes, then please fill question 1, if No then please skip this section

1. What are the reasons for your upcoming court dates?

Resources

Dependent Care Resources

Do you need resources for the care of your dependents? ☐ Yes ☐ No

If yes, then please explain below, if No then please skip this section.

Psychiatric Advance Directive

Do you have a Psychiatric Advance Directive? ☐ Yes ☐ No

If yes, please provide a copy of it to the front desk to be scanned into your chart when you hand them this form.

If you do not have a Psychiatric Advance Directive?, would you like to create one? ☐ Yes ☐ No

Legal Need Resources

Are you in need of legal assistance or support? ☐ Yes ☐ No

Vocational Need Resources

Do you need vocational assistance or support? ☐ Yes ☐ No

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date