TAMPA NEUROPSYCHIATRY

Patient info

Last name: _____ First Name:_____ M.I_____

Preferred Name_____ D.O.B____ /_____/_____ SSN:_____

Home Address:_____

_____

City:_____ State:_____ Zip code_____

Home Phone: _____ Cell Phone: _____

Email:_____

Employers Name: _____ Work Phone: _____

Please Check if acceptable for communication and confidential Messages:

_____ Home Phone _____ Work Phone _____ Cell Phone _____ Email

Emergency Contact

Emergency Contact: _____ Relationship: _____

Phone(s) _____

Primary Insurance

Name of Carrier:_____ Phone(s): _____

Claims Address: _____

City:_____ State:_____ Zip code_____

Group Number:_____

Insured: Name:_____Relationship to Patient: _____

TAMPA NEUROPSYCHIATRY

Patient Consent to Treatment

I hereby authorize FAIZI AHMED, M.D., Tampa Neuropsychiatry employees and agents to administer treatment. This in no way constitutes a warranty or guarantee that my present condition will be cured. FAIZI AHMED, M.D., Tampa Neuropsychiatry staff, and employees will provide me with the best possible care available but no assurance of cure is to be assumed. I sign this willingly and voluntarily in full understanding of the above, and in so doing I release FAIZI AHMED, M.D., its directors and officers, staff employees, agents and physicians from any and all liability which may arise from this action, whether or not foreseen at present. I understand that it is my responsibility to inform the doctor of my medical and psychiatric background. I understand that refusal to abide by prescribed treatment (eg: not taking or overtaking prescribed medications, missing or rescheduling appointments repeatedly) is basis for termination of care due to noncompliance. On this basis, I authorize to render the necessary psychiatric services, as deemed advisable and have been notified of any possible side effects of any medications I have been prescribed.

I understand and accept the Patient Consent to Treatment policy. Initial: _____

Release and Assignment of Benefits

I authorize FAIZI AHMED, M.D and Tampa Neuropsychiatry staff to release any medical information necessary to process my insurance claim(s). I hereby assign all medical, including major medical benefits to which I am entitled, private insurance and any other insurance programs to FAIZI AHMED, M.D and Tampa Neuropsychiatry. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all my charges whether or not paid by said insurance. If said insurance company has not made payments within 60 days, I understand that I will be responsible for any outstanding charges. This assignment will not apply when the balance has been paid as noted on claim form. If patient defaults in payment, patient agrees to pay collection costs and responsible attorney fees associated with the collection of outstanding balance.

I understand and accept the Release and Assignment of Benefits policy. Initial: _____

Treatment consent Form

I consent to psychiatric evaluation and treatment with Faizi Ahmed, M.D. and/or his associates. I further consent that if I initiate email contact with Dr. Ahmed or his staff, then that shall serve as my consent for Dr. Ahmed and his staff to communicate back to me via email, including the transmission of any confidential information regarding my case, via email. With this consent, I agree to not hold Dr. Ahmed nor any of his staff liable if there is a security breach or leak of any of my confidential information sent via email in this aforementioned manner. I give my permission to release any medical or psychological information regarding my treatment to my insurance company via phone, fax, email or correspondence. This authorization will not be used for any purpose other than stated. I may revoke this authorization in writing at any time. I have read and understand the above consent form.

I understand and accept the Treatment consent form policy. Initial: _____

TAMPA NEUROPSYCHIATRY

Paperwork and Forms

Forms that need to be completed by our physicians will have a fee of $50-$150 depending on the time and complexity of the form. This will have to be paid prior to the form being completed. Please allow 7-10 business days for required paperwork such as disability, return to work, or letters to specific individuals to be completed. (FMLA, Disability, Social Security, School, Letters) and 10 cent per page of printed files over 15 pages.

I understand and accept the Paperwork and forms fee policy. Initial: _____

Prescriptions and Refills

- Please obtain your prescription from your provider at the time of your appointment.
- Please make sure that you have enough medication to last until your next appointment.
- Medication over-rides will result in a **$75** charge for any required paperwork.
- No refill requests will be processed after 12 noon on Fridays.
- Second Prior authorization Fee: **$30** (First Prior authorization is free)
- Prescription Refill before appointment **$30**

Prescription refills or requests must have a follow up appointment scheduled as well as a 3-day notice must be given for all prescription refill requests. Prescription refills will not be phoned in the same day as the request. There will be no exceptions. You will need to be responsible and keep track of your medication. If you have cancelled or missed an appointment there will be a $30 charge for medication refills.

Narcotics: If you are prescribed a controlled substance and you misplaced the written prescription and/ or the medication itself, you will not be given another prescription until you are due. It is the patient's or guardian's responsibility to keep medication in a safe place. If you take more than you are prescribed and you do not discuss this matter with the physician/provider, you will not be granted an early refill without an appointment. If it is found that your prescribed medication is being misused this could result in immediate termination of care.

The State of Florida follows all controlled substance medication in a secure website. Tampa Neuropsychiatry does random checks on patients to see which controlled substances are prescribed. If it is found that you are getting the same medication from another physician this will be grounds for termination of care.

I understand and accept the Prescription and Refills fee policy. Initial: _____

TAMPA NEUROPSYCHIATRY

No Show and Cancellation Fees

For New Patient evaluations, you will be charged **$150** for cancellations that occur with less than a 48 hour notice prior to your appointment to the card on file. You will also be charged **$150** for no show appointments automatically to the card on file the day you miss.This fee is not covered by insurance and cannot be submitted for insurance reimbursement.

For follow up appointments, you will be charged **$75** for cancellations that occur with less than a 48 hour notice prior to your appointment to the card on file. You will also be charged **$75 automatically** for missed scheduled follow up appointments automatically to the card on file the day you miss. This fee is not covered by my insurance and cannot be submitted for insurance reimbursement.

In fairness to other patients and in order to provide safe treatment to engaged patients who are most likely to benefit, repeated no shows or late cancellations may be cause to discontinue treatment at our clinic.

I understand and accept the cancellation/No show fee policy. Initial: _____

Credit Card on File Policy

We have implemented a policy requiring a credit card held on file effective 8/1/2018. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit.

Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share, you will receive a statement. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. This is an advantage since it makes checkout easier, faster, and more efficient. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

I understand and accept the Credit card policy. Initial: _____

TAMPA NEUROPSYCHIATRY

Privacy Practices

RETURNED CHECKS: Returned checks will result in a fee of $50.00, along with the original amount due. This must be paid prior to any future appointments being scheduled or an approved payment arrangement. The payment arrangement will be decided on a patient to patient basis. The company has the right to refuse future checks from that patient.

FEES: Patients without insurance coverage must pay at the time of service. A new patient initial psychiatric evaluation is $ 300-450 and $100-150 for subsequent visits.

METHODS OF PAYMENT: Payments can be made in the form of Money Order, Credit Card, or Checks. Please make checks payable to: Tampa Neuropsychiatry.

MEDICAL RECORDS: Medical Records will be released with a completed HIPAA (Health Insurance Portability and Accountability Act) compliant medical record release.

PHONE VISITS: Tampa Neuropsychiatry does not do psychiatric visits or counseling over the phone. No exceptions.

INSURANCE: It is the patient's ultimate responsibility to know your insurance coverage. If it is found that a patients insurance does not cover psychiatric care, the patient will be responsible for payment in full. As a courtesy, we have estimated your insurance portion and will process your claim for you. You are required to pay your estimated patient portion on the day when services are performed. You are required to obtain the authorization for your initial visit and you are responsible for verifying on each subsequent visit that each visit has been authorized. We will verify your insurance coverage, but you are responsible if your insurance pays for the claim differently than we are informed.

If there are any delays on the part of your insurance company in the processing of the claim, it is your responsibility to contact the insurance carrier. We will expect payment in full from you if the insurance does not pay within 60 days of the service date. Any balance remaining after your insurance pays will be due and payable upon receipt of bill. Authorizations are based on medical necessity and are not a guarantee of payment by your insurance company.

I understand and accept the the outlined terms above. Initial: _____

Acknowledgement of Receipt of Privacy Practices

I Acknowledge that I have read a copy of the providers notice of private Practices and give consent to Tampa Neuropsychiatry to release information on an emergency basis only to the following people:

Signature_____

Date _____

TAMPA NEUROPSYCHIATRY

AUTOMATIC BILLING AND CREDIT CARD AUTHORIZATION FORM

Tampa Neuropsychiatry
2909 w Bay to Bay Blvd Suite 210
Tampa FL, 33629

FROM CREDIT CARD:

I authorize you to charge my bill directly to the credit card(s) listed below:

Primary Card Account	**Secondary Card Account**
_____	_____
Name on credit card (exactly as printed)	**Name on credit card (exactly as printed)**
_____	_____
Billing Address for credit card (Street, Apt. #)	**Billing Address for credit card (Street, Apt. #)**
_____	_____
City, State Zip	**City, State Zip**
_____	_____
Credit card number Expiration Date	**Credit card number Expiration Date**
_____	_____
Signature Today's Date	**Signature Today's Date**

☐ Bill all charges to the above card(s). Since the payment amount may vary, I will receive written notification of the amount and date of the next charge prior to each scheduled transaction date.

☐ This authorization is valid until I provide you with written cancellation.

Tampa Neuropsychiatry
Dr. Faizi Ahmed, MD
www.Tampaneuropsychiatry.com

Office: 813-995-1775 Fax: 813-642-4877

TAMPA NEUROPSYCHIATRY

2909 W Bay to Bay, Suite 210 Tampa, Fl
33629 Phone:813-995-1775 Fax:
813-642-4877
Faizi Ahmed, MD

Patient Name: _____ Date of Birth: _____

Referred by: _____

Reason for Visit: _____

_____

Current psychiatric medications and doses: _____

_____

_____

_____

_____

PHARMACY INFORMATION:

Name of Pharmacy: _____

Phone Number: _____

Fax Number: _____

Address: _____

_____

PRIMARY CARE PHYSICIAN INFORMATION:

Is it okay to contact your Primary Care Doctor?

☐ **Yes** ☐ **No** ☐ **I do not have one**

(If yes, please fill out accompanying Release of Information at the end of the packet)

Doctor's Name*:* _____

Phone Number*:* _____

Fax Number*:* _____

Address*:* _____

_____

TAMPA NEUROPSYCHIATRY

Please check all that apply:

- ☐ Depressed mood
- ☐ Hopeless or helpless
- ☐ Don't do pleasure or leisure activities like I use to
- ☐ Feelings of guilt
- ☐ Feelings of worthlessness
- ☐ Low self-esteem
- ☐ Decreased energy
- ☐ Decreased concentration
- ☐ Appetite or weight changes
- ☐ Moving slower or speaking slowly
- ☐ Feeling fidgety or have feeling of inner restlessness
- ☐ Sex drive changes
- ☐ Fatigued / tired most days
- ☐ Feel irritable often for no reason
- ☐ Harder to make decisions than I use to
- ☐ Sleep problems
  - ☐ Hard to get to sleep, but I stay asleep
  - ☐ Hard to stay asleep, but I get to sleep okay
  - ☐ Hard to get to sleep and hard to stay asleep
- ☐ Ideas of suicide or death
- ☐ Anxious
- ☐ Panic attacks
- ☐ Fear of social situations
- ☐ Obsessions
- ☐ Compulsions

- ☐ Do you feel threatened or scared?
- ☐ Are people out to get you?
- ☐ Can you read people's thoughts?
- ☐ Can other people read your mind or know your thoughts?
- ☐ Does the TV or radio talk to you?
- ☐ Hear voices others can't?
- ☐ See things others can't?
- ☐ I have intrusive thoughts that are not my own
- ☐ I have special abilities or powers others do not have
- ☐ Thoughts are put inside my head by others
- ☐ I sometimes have out of body experiences

- ☐ Mood swings or irritability
- ☐ Anger outbursts
- ☐ Decreased need for sleep
- ☐ More talkative
- ☐ Racing thoughts
- ☐ At times, I become overly distractible where even small things pull me away from important things.
- ☐ At times, I do more risky things than usual or I spend money of control or get involved in sex or other adventures that often turn out badly
- ☐ At times, I do more Impulsive than usual and do things that are totally out of character for me
- ☐ At times , I start many projects or get into so many activities that I can't complete and I jump from one to another rapidly
- ☐ At times, I am unusually irresponsible and take action that cause moderate to severe problems (legal, financial, relationship) for me and my family

- ☐ I have experienced a traumatic event
- ☐ I often have the same nightmare or bad dream
- ☐ Memories come into my mind when I don't want them
- ☐ Sometimes I feel numb all over when I have some memories
- ☐ I avoid certain people and places I go
- ☐ Sometimes I feel so much fear that I detach myself or feel disassociation from people or places
- ☐ I am hyper-vigilant / hyper-aware even when no danger is present
- ☐ I have many body aches and pains
- ☐ I have neck, back and other chronic pain
- ☐ I have headaches / migraines often
- ☐ I have had a head injury in the past

TAMPA NEUROPSYCHIATRY

Psychiatric History

Past Psychiatrist / Therapist: _____

Date Last Seen: _____

Past Psychiatric Diagnosis: _____

Past Psychiatric Medications: _____

_____

_____

_____

_____

_____

1. Have you ever been hospitalized for any psychiatric reasons? YES ☐ NO ☐

If yes, how many times? _____

What was the reason? _____

What was the date? _____

Where were you hospitalized? _____

2. Have you ever been placed under a Baker Act? YES ☐ NO ☐

If yes, why were you Baker Acted? _____

What was the date/dates? _____

3. Have you ever attempted to commit suicide? YES ☐ NO ☐

If yes, **how** did you attempt to kill yourself? _____

How many times did you attempt suicide? _____

What was the date(s)? _____

TAMPA NEUROPSYCHIATRY

Medical History

Current Medical Issues: _____

_____

_____

_____

_____

_____

Current Non-psychiatric Medications: _____

_____

_____

_____

_____

_____

Allergies: _____

_____

_____

Surgical History

Past Surgeries (Include date/hospital/physician): _____

_____

_____

_____

TAMPA NEUROPSYCHIATRY

Family Psychiatric History (*please check all that apply & list family member*):

□ Depression - family member(s): _____

□ Anxiety - family member(s): _____

□ Bi-polar - family member(s): _____

□ Schizophrenia - family member(s): _____

□ Suicidal Attempts-family member(s): _____

□ ADD / ADHD - family member(s): _____

□ Alcoholism - family member(s): _____

□ Drug abuse - family member(s): _____

□ Dementia - family members(s): _____

Social History

Smoking status (please check one that applies):

☐ Current Smoker ☐ Former Smoker ☐ Never Smoker

Alcohol consumption (please check one that applies):

☐ Non-Drinker ☐ Occasional ☐ Social ☐ Rare

Daily, Drinks per day.

I usually drink ☐ Beer ☐ Wine ☐ Liquor

Do you have a history of substance or alcohol abuse? YES ☐ NO ☐

If so, please explain: _____

_____

Have you ever been treated for substance abuse? YES ☐ NO ☐

If so, where were you treated? _____

What was the date? _____

TAMPA NEUROPSYCHIATRY

Marital Status (please check one that applies):

Single ☐ Married ☐ Divorced ☐ Widowed ☐

How long: _____

Children: _____

Employment Status (please check one that applies):

Employment ☐ Unemployed ☐ Disability ☐ Retired ☐

Employer: _____

IF on disability, please explain why: _____

_____

Education Level: _____

Currently Residing With (please check one that applies):

☐ I am living alone

☐ I am living with a family member

☐ I am living with a spouse or significant other

Other: _____

TAMPA NEUROPSYCHIATRY

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name _____ **Date** _____

Provider _____ **Patient ID #** _____

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half 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:				
	Healthcare professional: For interpretation of TOTAL) Please refer to accompanying scoring card.)		+	+	

10 If you checked off *any* problems, how *difficult* 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 _____