Deepika Bhargava MD PA
www.doctorhealsmind.com

McKinney Location:
4801 Medical Center Dr.
McKinney, TX 75069
Phone: 972-369-4220
Fax: 214-540 9470

Sherman Location:
600 East Taylor St, #4001
Sherman, TX 75090
Phone: 903-892-0751
Fax: 214-540 9470

Personal Details

Date: _____ Name: _____ DOB: _____ Age: _____

Address: _____

SSN#: _____ Wk. Phone: _____ Cell Phone: _____

Email Address: _____ Employer/School: _____

Sex: [ ] Male [ ] Female [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated [ ] Other: _____

Primary Insurance

Insurance: _____ Policy/Member ID#: _____ Group#: _____

Insurance Holder (Name):_____ DOB: _____ SSN#: _____

Relationship to Patient: _____

Secondary Insurance

Insurance: _____ Policy/Member ID#: _____ Group#: _____

Insurance Holder (Name):_____ DOB: _____ SSN#: _____

Relationship to Patient: _____

I, _____, have provided the above information accurately and to the best of my knowledge. It is my responsibility to notify Dr. Bhargava's office of any changes of insurance or demographic information. I understand that payment of co-pay/co-insurance, are due before any services are rendered. I certify that I, and/or my dependents have insurance coverage, and I assign directly to Dr. Bhargava M.D P.A all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the signed below date.

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Address: _____

_____
Signature of Patient, Parent, Guardian, or Representative Date

My Primary Care Physician is: _____
My last physical was: _____

History of Past Illness:
[ ] Measles [ ] Rheumatic Fever or Heart Disease [ ] Mumps
[ ] Congenital Abnormalities [ ] Chicken Pox

Adult:
[ ] Asthma [ ] High Blood Pressure [ ] Cancer (Site):_____
[ ] Diabetes [ ] Ulcer or Gastritis [ ] Thyroid Problems
[ ] Tuberculosis [ ] Kidney Problems [ ] Liver Problems
[ ] Blood Problem [ ] Venereal Disease [ ] Heart Failure
[ ] Heart Attack [ ] Abnormal Heart Rhythm
[ ]Osteopenia [ ] Osteoporosis [ ] Fibromyalgia

Operations:
Have you had any surgeries? [ ] Yes [ ] No
If yes, please explain: _____
_____
_____

Allergies: _____
_____

Current Medications: _____
_____
_____
_____
_____

Have you been on **PSYCHIATRIC** medication in the past? [ ] Yes [ ] No If yes, please list:

Medication	Dosage	First/Last time you took it	Effect of medication

Past Psychiatric Care

(List all Psychiatrist, Therapists, Counselors, and Hospitalizations)

Date(s) seen? By Whom?	For what problem?	What treatment (meds, TMS, ECT, therapy)?

Substance Abuse

Please indicate for each drug listed below

Drug	Ever used?	Age at 1st use	Time since last use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Do you have any concerns regarding sexual function? [ ] Yes [ ] No
Foreign Travel within the past year? _____
Coffee _____ Tea_____ Colas _____ per day
Alcohol [ ] Never [ ] <1 per week [ ] 1-5 per week [ ] other _____
Tobacco [ ] Never ___ Packs per day Quit ___ years ago

Social History:

Are you employed? [ ] Yes [ ] No
What is your job? _____
_____
_____
Are you a student? [ ] Yes [ ] No
Where? _____
Grade School [ ] College [ ] Postgraduate [ ]
Do you wear seatbelts? [ ] Always [ ] Sometimes [ ] Never
Has a parent, sibling, child, grandparent ever had psychiatric problems, substance abuse, or treatment? If so, what type of illness and treatment?
_____
_____

Sexual Orientation:

[ ] Heterosexual [ ] Homosexual [ ] Bisexual [ ] Choose not to answer

Please describe any other symptoms or experiences you have had problems with:
_____
_____
_____

Injuries:

Have you ever been in a serious motor vehicle accident? [ ] Yes [ ] No
Have you ever had any concussions or head injuries? [ ] Yes [ ] No
Have you ever been knocked unconscious? [ ] Yes [ ] No

Do you have a family history of diabetes [ ] Yes [ ] No
Has anyone in your family attempted or committed suicide? [ ] Yes [ ] No

Systemic Review:

Current weight: _____ Max weight: _____
Min weight: _____ Height: _____
Have you recently had:
[ ] Weakness [ ] Fever
[ ] Chills [ ] Fainting [ ] Problems Sleeping
[ ] Night Sweats

Skin:

Skin Disease [ ] Yes [ ] No
Jaundice [ ] Yes [ ] No
Hives, eczema, rash [ ] Yes [ ] No

Head Eyes Ears Nose Throat:

Dry eyes or mouth [ ] Yes [ ] No
Bleeding gums [ ] Yes [ ] No
Blurred vision [ ] Yes [ ] No
Date of last eye exam:_____
Nosebleeds – frequent [ ] Yes [ ] No
Chronic sinus trouble [ ] Yes [ ] No
Ear disease [ ] Yes [ ] No
Impaired hearing [ ] Yes [ ] No
Dizziness or room spinning [ ] Yes [ ] No
Frequent or severe headaches [ ] Yes [ ] No

Respiratory:

Asthma or wheezing [ ] Yes [ ] No
Difficulty breathing [ ] Yes [ ] No
Pleurisy or Pneumonia [ ] Yes [ ] No
Cough up blood (ever) [ ] Yes [ ] No

IF YOU HAVE ANY QUESTION AND / OR CONCERNS REGARDING ETHICAL ISSUES, THEY MAY BE DIREDCTED TO THE FOLLOWING CONSUMER HOTLINE AT 1-800-942-5540.

HIPAA Notice of Privacy Practices

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health services.

1. **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the regulations od Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information

You have the right to issue and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation or, or in use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply

Your physician is not required to agree to a restriction that you may request. If your physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative mean means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

Communication Form

I _____certify that the following person(s) can receive, send, or communicate on my behalf.

The following person(s) may send, receive or communicate on my behalf:

Name:_____ Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient Name:_____Date of Birth:_____

Patient Signature:_____Date:_____

Parent or Legal Guardian:_____

Patient Communication Consent Form

I agree to allow Deepika Bhargava MD PA to contact me in the following methods regarding my private health information and general information regarding the practice.

Method	Number/Address	Messages (Yes or No)	
☐ Home Phone	(___)_____	☐ Yes	☐ No
☐ Work Phone	(___)_____	☐ Yes	☐ No
☐ Cell Phone	(___)_____	☐ Yes	☐ No
☐ Voice Mail	(___)_____	☐ Yes	☐ No
☐ Text Messages	(___)_____	☐ Yes	☐ No

(Texting requires that you give us your cell number and for you to have a text enabled cell phone

☐ Email	(___)_____	☐ Yes	☐ No
☐ Physical Mail	(___)_____	☐ Yes	☐ No

I understand the risk associated with the different methods of communication (especially e-mail and texting), and consent to the conditions, restrictions, and patient responsibilities.

Patient Name (Printed):_____ Date:_____

Patient Signature:_____

Client Email/Texting Informed Consent Form

1. Risk of using email/texting

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.

c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.

d. Employers and on-line services have a right to inspect emails sent through their company systems.

e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.

f. Email and texts can be used as evidence in court.

g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts

Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Provider is not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.

b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.

d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.

e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.

f. Provider is not liable for breaches of confidentiality caused by the client or any third party.

g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Provider may impose to communicate with me by email or text.

Client name: _____

Client signature: _____ Date: _____

Parent/Legal Guardian name: _____

Parent/Legal Guardian signature: _____ Date: _____

Provider name: _____

Provider signature: _____ Date: _____

Consent to Treat

Deepika Bhargava MD PA (Clinic) is committed to providing high quality services and all the information necessary to be informed about the treatment process. If you agree to the stipulations, please initial in all sections and sign the last page of this form as you consent to treatment with the Clinic. The Clinic maintains personnel and facilities in order to provide medical/psychiatry care. By consenting to this treatment agreement, I authorize the staff to provide services in office via. telephone, telepsychiatry. The consent is applicable to all providers at the Clinic and services can be rendered by different providers based on availability. **INITIAL _____**

Confidentiality
The Clinic is committed to confidentiality to the fullest extent allowed by Texas law. There are several exceptions. The following are common: a.) any evidence of child abuse (past or present) must be reported. b.) If any individual intends to take harmful, dangerous, or criminal actions against another human being or against him/herself. It is our duty to report such actions or intent to the authorities. c.) Sexual improprieties by a former therapist or psychiatrist are a criminal offense and must be reported. You have certain rights in such reporting which your physician can explain to you. d.) Certain court order / action such as custody cases, malpractice actions and criminal cases. e.) Collection of fees. f.) Prenatal exposure of controlled substances. g.) In event of death – the spouse or parents of deceased may access their child/spouse records. h.) Minors/Guardianship – parents/legal guardians of non-emancipated minors have right to access client records. If you have questions about this area, please feel free to discuss with your physician. **INITIAL_ _____**

Fees and Insurance

The initial diagnosis and evaluation is $375.00. Follow up medication checks are between $185.00 and $225.00 for Private pay rates. This means that a patient that does not have insurance coverage will be charged this amount. Some insurance companies may cover part of this cost. If you have coverage, you are welcome to assign the benefits and pay only your co-pay or coinsurance at the time of each visit. If your policy deductible has not been met, you are responsible for payment at the time of the visit. Law does not allow us to waive deductibles or co-payments. **INITIAL _____**

By consenting to treatment, you acknowledge that you are responsible for the cost of these services provided to you or your minor child and agree to pay them when billed or at time or service. If services are not paid, then you agree to pay a service charge as well as any finance charge that may apply. After 90 days, the account may be assigned to an outside agency, in which case you will be responsible for paying attorney fees and / or collection fees and expenses. Outstanding balances past 90 days will be charged $25.00 for collection fees. **INITIAL _____**

It is important that if you choose to utilize your insurance, we will be obligated to provide them certain information about your case including but not limited to diagnosis, type and dates of services. By assigning benefits to the Clinic you are authorizing them to provide your insurance carrier or their intermediary whatever information is necessary to process the claim. If you choose to utilize your insurance it may affect your insurability in the future. If at any time you have questions about the fees or insurance, please feel free to discuss them with the staff.

I understand that the practice will, as a courtesy to me file on my behalf. I understand and agree that I am ultimately responsible for an any and all fees not covered by my insurance carrier. I understand that my insurance policy is a contract between my insurance company and me and therefore will not hold the Clinic for denial of coverage or for negotiating claims with the insurance company and the insurance company and other individuals. I agree that copays and non-covered services are payable at the time of service unless other arrangements have been made. In the event that my insurance carrier declines my benefits, I acknowledge and agree that I am fully responsible for the declined charges and can expect them to be applied to my account and charged to my credit card on file. **INITIAL ____**

Appointments

If you need to cancel an appointment, a 24-business hour notice is required. If you miss or cancel a follow-up appointment without a 24-business hour notice, you will be charged $75.00 for the missed appointment. If you miss or cancel your initial appointment without a 24-business hour notice, you will be charged $150.00 for the missed appointment. Missed appointments cannot be filed with insurance. Therefore, you are solely responsible for the entire fee. **INITIAL _____**

Returned Checks

There is a $50.00 charge for any returned checks**. INITIAL _____**

Right to withdraw from treatment

If a conflict arises for the client or the physician, either one has the right to withdraw from the treatment process. If the physician feels the need to withdraw from providing treatment, she will inform the client and provide appropriate referrals and 30 day emergency care. **INITIAL _____**

Phone Consultations
We provide phone consultations in lieu of regular follow ups. The cost of this service is $150. I understand that these consultations are not billable to my insurance carrier. The clinic reserves the right of charging $25 for every 15 minute of support staff time, which is not included in the $150.00. **INITIAL _____**

Record Storage / Interruptions in service
If an unforeseen even occurs (such as serious illness or death etc.) which renders your physician unable to provide services, a referral will be made until the physician is able to return to work. Records are stored for seven years per legal requirements. **INITIAL _____**

Medical records
If you need a copy of your medical record, you must give this office a signed notification from the patient and a 2-week notice. The charge for medical records is $40.00. **INITIAL _____**

Forms, Letters Request
You will be responsible for cost of completion of forms. The fees may vary depending on amount of time in preparing and processing the forms. The rate varies from $150 to $300. The amount is payable at the time the request is made.

Legal Actions/Court Appearance
If legal actions occur in which your physician is requested or subpoenaed to provide testimony (such as in custody cases) you will be responsible to provide the following even if the subpoena is sent from the opposing side of the case: a.) travel expenses b.) hourly or per diem fees based on our existing fees from the time the physician leaves the office until she returns. At least 50% of the anticipated cost will be expected prior to the court appearance. Record copying is $40.00. Physician fees: $600 per hour (minimum 6 hours will be billed). Staff preparation: $200 per hour **INITIAL _____**

Language/Culture
If cultural or language differences may negatively impact prospects of successful treatment, you may ask for a referral to a physician of your culture or who speaks your language. Your physician will assist in such a referral if one can be found. **INITIAL _____**

Danger
In the event that your physician, in her clinical judgment believes you to be dangerous to yourself or to someone else, by signing this consent you authorize her to contact either the person listed as your emergency contact or someone else to provide assistance through this crisis situation. **INITIAL _____**

Coverage/Emergencies
If you have a life-threatening emergency, please go to the nearest emergency room or call 911. In an emergency situation, the office manager can be reached after hours and messages forwarded to your physician. Calls are returned as soon as possible; however, in the event that your physician is unavailable, you may call the Suicide and Crisis Center at any time. You may be treated by one of our covering Psychiatrist on call during any inpatient hospitalization. Non-emergency phone calls will be returned the following business day. **INITIAL _____**

Medication Refill Policy
There is a $25.00 charge for each prior authorization that our office is required to obtain. This fee has to be paid before the prior authorization is processed, for medications that are not listed on the formulary list for your insurance company. The Clinic advises each patient to obtain a copy of your formulary list prior to your visit, to ensure that the medications being prescribed are covered by your insurance company, and to give you the opportunity to discuss alternatives if possible. This will help to avoid charges incurred secondary to this policy

The Clinic does not refill prescriptions through pharmacies, please ensure that you check your medications and bring a list of medications that need to be refilled to your office visit. If you need a prescription refilled, it is important to have this done at the time of your appointment. If for any reason you need a prescription refilled outside of your appointment time there will be a $25.00 charge. I understand that a prescription request needs to be made 72 hours in advance and non-emergency messages regarding the prescription medication will be returned in 72 business hours. Medication requests are addressed only during business hours.

If you have read and understand these aspects of consent, please sign below. If you would like a copy of this consent form, for your records, the Clinic will be happy to provide you with one. If you have any questions about any of the information on this form, discuss them with your physician and wait to sign the form with the Clinic. Insurance questions may be addressed by Clinic personnel. By signing this form you acknowledge that all questions have been fully answered and you agree to terms of this agreement. **INITIAL _____**

Electronic Signatures
I agree that if this agreement or related documents are signed when party's signature are delivered by fax, email or any other electronic medium. These signatures are and must be treated in all respects as having the same force and effect as original signatures. **INITIAL ___**

Termination of Services
I understand and agree that I am entering into a therapeutic relationship with my provider. The success of the treatment is contingent upon active participation and constant attendance. More than three No Shows will result in termination of services. Your file will be closed after 60 days of zero communication and no appointments.

My signature below affirms that I have read and understood the service agreement and office policies of the Clinic. I acknowledge that all of my questions have been fully answered. I further acknowledge, understand and agree that such terms may be amended from time to time to meet the needs of the practice.

_____
Name of Responsible Party (print)

_____ _____
Signature Date

_____
Witness Signature Date

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www.doctorhealsmind.com

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Sherman, TX 75090
Phone: 903-892-0751
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Financial Agreement and Credit Card Authorization Form

I fully understand and agree to the financial terms and policies of the clinic, set forth and acknowledged in consent to treat document.

I have read and I acknowledge that I will be responsible for any such service provided in good faith. I understand that I am fully responsible for declined charges set forth by the clinic as explained in the consent to treat document and authorize the clinic to charge any outstanding balances on my account, including, but not limited to, charges for no-show fees, phone consultation fees, prescription refill fees, as well as fees for prior authorizations for medications. Any services billed to my insurance, if not paid in 60 days, will be assessed on private pay basis and my credit card will be charged for that amount on 60th day after service.

AMEX Visa MasterCard Discover

Credit Card Number: _____

Expiration: _____ CVV: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Deepika Bhargava M.D P.A

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Fax: 214-540-9470

Sherman
600 E. Taylor Street Suite 4001
Sherman, TX 75090
Phone: 903-892-0751
Fax: 214-540-9470

Authorization to Use, Disclose or Release Health Information

Patient Name: _____ Date of Birth: _____

Telephone: _____ Home Address: _____

I authorize my [ ] Primary Care Physician, [ ] Psychiatrist, or [ ] any other health care provider, to disclose/release my protected health information to Deepika Bhargava, MD or Emad Khan MD.

Name: _____ Phone #: _____ Fax #:_____

The protected information to be released is as follow(s):

[ ] History and physical
[ ] Discharge Summary
[ ] Lab results
[ ] Progress notes
[ ] All records
[ ] Operative Report
[ ] Pathology Report
[ ] X-Ray imaging records
[ ] Entire chart
[ ] Other (specify what is to be used, disclosed or released): _____

_____ Patient Signature

_____ Today's Date

Date	Faxed To	Fax #	By	Received