HEALTHY MINDS
PSYCHIATRY SERVICES INC.

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus. A weak or compromised immune system can put you at greater risk for contracting COVID-19.

Please indicate	**Yes/No**
Do you have a fever or above normal temperature?	☐ ☐
Have you experienced shortness of breath or had trouble breathing?	☐ ☐
Do you have a dry cough?	☐ ☐
Do you have a runny nose?	☐ ☐
Have you recently lost or had a reduction in your sense of smell?	☐ ☐
Do you have a sore throat?	☐ ☐
Have you been in contact with someone who has tested positive for COVID-19?	☐ ☐
Have you tested positive for COVID-19?	☐ ☐
Have you been tested for COVID-19 and are awaiting results?	☐ ☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐ ☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐ ☐

NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with public places including medical offices. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

I confirm that I have read the Notice above and understand and accept that there is a risk of contracting the COVID-19 virus in any medical office. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature: _____ Date: _____

Witness: _____

HEALTHY MINDS
PSYCHIATRY SERVICES INC.

Personal Information:

First Name:_____ M.I.____ Last Name:_____

Sex: _____ Age: _____ D.O.B: _____

Marital Status: _____ S.S #: _____

Home Address:_____

E mail: _____

Home Phone:_____ Cell:_____

Have you been hospitalized in the past year? YES NO

Do you have any Allergies? YES NO

Are you Pregnant? YES NO N/A

Emergency Contact: _____ Tel: _____

Employer Name:_____ Tel:_____

Referral Name: _____ Tel: _____

Preferred Pharmacy:_____

Pharmacy Tel:_____

Primary care Provider Name :_____ Tel: _____

Have you been treated by a Psychiatrist before? YES NO

If Yes, please explain: _____

Are you taking any Medications: YES NO

If yes, please list here: _____

Insurance Information:

Insurance Company Name: _____ Policy #: _____

Group#: _____ Phone #: _____

Policy Holder: _____ D.O.B: _____

AUTHORIZATION TO **OBTAIN / DISCLOSE** PROTECTED HEALTH INFORMATION FORM

Healthy Minds Psychiatry Service, Inc.

19415 Deerfield Avenue, Suite #209, Lansdowne, VA-20176

Please Print Clearly

Patient Name: _____

Last First Initial

Address: _____

Street City State Zip code

Phone ( ) _____ DOB _____

I authorize to disclose the above-named protected health information,

FROM;

Name: _____

Address: _____

Phone: _____ Fax: _____

TO;

Name: _____

Address: _____

Phone: _____ Fax: _____

The type and amount of information to be used or disclosed is as follows: (please check all that apply)

☐H&P ☐Progress Notes ☐Psychotherapy Notes

☐Labs ☐Discharge Summery ☐Neuropsych. Testing

☐Entire Record ☐Billing Record ☐Substance Abuse

☐Other/Specific _____

I understand that I have the right to revoke this authorization at any time. I also understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released/received.

Unless revoked this authorization will expire on date, event or condition _____

Patient Signature: _____. Date: _____ Time: _____

Legal Representative: _____.Date: _____ Time: _____

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Dr. Kumar Bahl-Psychiatrist.
19415 Deerfield Avenue. St. 209
Lansdowne, VA-20176
Phone: 571-559-2100. Fax: 571-559-2101
www.healthymindspsychservices.com

HMPS-Patient Services Agreement/Consent Form

Welcome to Healthy Minds Psychiatry Services (HMPS) where we strive for excellence in providing the highest quality of psychiatric care to our late adolescent to adult and geriatric patients. To achieve this goal, we must have a mutual understanding regarding our professional services and your participation in your own treatment. This document contains important information about our services and business policies. **Please read them carefully.**

HIPAA: The Health Insurance Portability and Accountability Act (HIPAA), a Federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. You may revoke this agreement in writing at any time. Please feel free to ask any questions regarding this matter at your first appointment. For more information **please visit www.hhs.gov**

Confidentiality: Your privacy is important to us. All protected health information (PHI) will be kept confidential. In most cases we will obtain your consent prior to releasing any PHI; however, records and/or PHI may be released regardless of consent in the following circumstances:

- According to state and local laws, we must report to the appropriate agencies all cases of physical and sexual abuse or neglect of minors (children under the age of 18), the disabled, and the elderly.
- According to state and local laws, we must report to the appropriate agencies all cases in which there exists a danger to self and/or others.
- When authorized by the recipient of services, to process medical insurance claims and authorized payment of benefits.
- If a patient needs emergency services and other medical personnel need to be contacted.
- If you become involved in specific kinds of legal proceedings, the courts may

subpoena information concerning your treatment.

Office Hours: The office is usually open Monday-Fridays, 9 AM to 6 PM and Saturdays from 9 AM to 1 PM by appointment. Information regarding holidays or vacations would be communicated in advance via telephone voicemail and website

Psychiatric Services:

We offer the following psychiatric services:

- Initial diagnostic interview.
- Follow up with medication evaluation, management, and therapy.
- Individual psychotherapy.

Payment and Billing Policy: Payment (i.e. cash pay, copays, payment towards deductible) **is due prior to your appointment on the day services are rendered.** If we are an in-network provider for your insurance, we will collect the portion of the fee that the insurance does not cover. Unless proof from the insurance company is provided at the time of the appointment stating that your deductible has been met, all deductibles will be due at the time of the appointment. If your account is not paid in a timely manner and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency, hiring an attorney, or utilizing other options, which will require me to disclose otherwise confidential information. In most collection situations, the information released includes the patient's name, contact information, the nature of services provided and the amount due. If such legal action is necessary, these costs will be included in the claim.

We do not accept checks but do accept cash (exact amount) and credit card payments (Visa, Mastercard, American Exp, and Discover).

*If there is a change in your insurance coverage, your address, or other important demographic information between appointments, please let us know when you check in.

Cancellation Policy: Once an appointment is scheduled, you will be expected to arrive on time and pay for the visit, unless you provide at least one business day's advance notice of cancellation. For example, an appointment for Monday needs to be cancelled before close of business on the Friday before, to avoid a missed appointment charge. Please know that insurance companies do not provide reimbursement for no-show appointments and/or appointments that you do not cancel with sufficient notice. A missed appointment fee will be charged for an appointment not cancelled with sufficient notice or for a no-show appointment. For example, if a 30-minute appointment is missed, you will be charged my fee for that type of appointment. As a courtesy, we try and confirm upcoming appointments by phone. Please realize that you are responsible for appointments that you schedule.

you. Otherwise, prescriptions need to be picked up from our office during normal business hours

Follow up visits: We require that patients on psychiatric medication be seen at least once every 90 days. If a patient has not been seen in the office in the last 90 days, we will not issue a refill without a scheduled follow-up appointment.

Forms and Letter: Any additional paperwork, letters, or forms not specifically related to intra-office care, will be subject to a fee based on the time it takes to complete the documentation ($15 for up to 10 mins, $25 for 11-30 min, $50 for 31-60 min, etc.) which will need to be paid prior to release of the paperwork.

Consent to Disclose: List below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from Healthy Minds Psychiatry Services.

Name and Relations Allowed

Spouse: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Consent for Treatment: I have read the entire agreement and I fully agree with its contents. I voluntarily give my permission to the healthcare providers of Healthy Minds Psychiatry Services as they may deem necessary to provide mental health services to me.

I understand by signing this form, I am authorizing the clinicians of Healthy Minds Psychiatry Services to treat me for as long as I seek care from them until I withdraw my consent in writing.

Signature: _____ Print Name: _____ Date: _____

Legal guardian name (if applicable): _____

Signature: _____ Date: _____