Arpan Parikh MD Inc

NEW PATIENT REGISTRATION FORM

Today's Date:			Primary care doctor:		
PATIENT INFORMATION					
Patient's last name: First:		Middle:	Marital status:		
Is this your legal name? ◉ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
Home Address:					
Social Security number:	Cell phone number:		Home phone number:		
Occupation:	Employer:		E-mail address:		
Referred by:					
Other family members seen here:					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):	Relationship to patient:		Cell phone no.:	Home phone no.:	

The above information is true to the best of my knowledge. I understand that I am financially responsible for the full cost of all treatment.

Patient/Guardian signature

Date

Arpan Parikh MD Inc
Practice Policies and Procedures

I will seek to provide the best care possible to help you in your pursuit of wellness and recovery.

Evaluations

- Your initial evaluation will be scheduled for at least 90 minutes (and may require more than one session); during this time, both you and Dr. Parikh will determine your goals of treatment and develop a proposed treatment plan. A primary goal of this initial session is to determine if there is a good fit to establish treatment; as such, completing an initial evaluation is not a guarantee of continued treatment with Dr. Parikh. If continuing with Dr. Parikh is not recommended, you will be provided with the clinical rationale as well as recommendations for alternate levels of care.
- Dr. Parikh will use evidence-based treatments and inform you if we are trying a medication or treatment that has not been well established for a particular problem.

Follow-up Appointments

- After the initial evaluation, all follow-up appointments will be scheduled for 45 minutes in length, whether for psychotherapy only or for psychotherapy + medication management
- Dr. Parikh will determine the time frame for follow-up appointments, reflective of the frequency required to deliver high quality care. If Dr. Parikh determines there has been insufficient follow-up to safely continue prescribing your medication, he may decline to renew your prescription (or provide only a partial refill) until your next appointment.
- If Dr. Parikh is prescribing medication as part of your treatment plan, you will be required to provide a copy of a full physical examination completed by a primary care clinician in the last 12 months. Additionally, Dr. Parikh may request copies of lab results from your primary care clinician, or order labs either before starting a medication or as routine monitoring while you are prescribed medication. If labs are ordered, the practice partners with LabCorp; you will be responsible for determining your financial responsibility for the labwork with LabCorp directly.
- If you are prescribed controlled substances as part of your treatment plan (including but not limited to benzodiazepines, stimulants, some sleep agents, and opioid agonists), you will be provided with our *Controlled Substance Prescription Policy*

Cancellations

- You are requested to provide at least 48 business-day hours advance notice of cancellation. Late cancellations (including failure to cancel or arriving more than 15 minutes late for an appointment) will result in a full charge for the session. Even if you have out-of-network benefits, your insurance company will not cover charges for missed appointments.

Fee Schedule and Payment

- Initial evaluations are billed at $800/session, 45-minute follow-ups are billed at $475, and 25-minute follow-ups are billed at $350
- We are considered 'out-of-network' and do not accept any insurance (including but not limited to commercial plans, Medicare, and Medicaid)

- Payment for sessions is expected at the end of each session (via credit card on file); if you see Dr. Parikh weekly, you may request to pay the outstanding balance at the end of each month
- At your request Dr. Parikh will provide a clinical summary receipt, which you can submit to your insurance company if you have out-of-network benefits; Dr. Parikh will not submit any documentation to the insurance company on your behalf
- Medications prescribed may require prior authorizations from your insurance company; in this event you are responsible for providing Dr. Parikh with the relevant documents and information to facilitate this process (and agree Dr. Parikh may release any and all clinical information to your insurance company and pharmacy)

Contacting the Practice

- Emergencies: if you think your concern poses an immediate risk to your own safety or the safety of others, you should proceed directly to the closest emergency room or call 911. If you are located within Los Angeles County, you may call the LACDMH Help Line 24/7 at 1-800-854-7771
- Non-urgent messages: for non-urgent administrative messages (e.g., scheduling, billing, etc.) please email Dr. Parikh at arpan@arpanparikhmd.com (you will receive a response within 24 business-day hours)
- Urgent messages: for urgent issues please contact Dr. Parikh at 347-927-0417; if you are unable to reach the practice and have an emergent issue, please call 911 or proceed directly to the closest emergency room
- Please note that text messages to the above number are not routinely monitored and should not be used as a mode of communication

Technology

- Telehealth refers to providing psychiatric services remotely using telecommunications technology, such as video conferencing
- One of the benefits of telehealth is that you and Dr. Parikh can engage in services without being in the same physical location; this is particularly helpful given the current COVID-19 pandemic
- As telehealth sessions take place outside of the clinic, there is potential for others to overhear sessions; on our end we will take reasonable steps to ensure your privacy. It is important, however, for you to find a private place for our session where you will not be interrupted
- There are many ways that technology issues might impact telehealth; for example, technology may stop working during a session
- If a session is interrupted for any reason and you are having an emergency, do not call Dr. Parikh back; instead call 9-1-1 or proceed directly to your nearest emergency room. You can call Dr. Parikh back after you have obtained emergency services.
- If the session is interrupted and you are not having an emergency, disconnect from the session and Dr. Parikh will wait two minutes and re-connect on the same platform; if Dr. Parikh does not re-connect within two minutes, please call Dr. Parikh at 347-927-0417

- If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time

Legal Proceedings

- Dr. Parikh reserves the right not to participate in legal proceedings. If Dr. Parikh agrees to participate, the specific limitations and fees will be established in writing with you and your legal counsel in advance or providing the service.

Referrals/Terminations

- An initial decision to initiate treatment is not a guarantee that Dr. Parikh will be able to continue to provide treatment under all clinical circumstances. If it is determined that your treatment needs change over time, Dr. Parikh may either refer you for adjunctive treatment, or recommend that all of your care be transferred to another clinician/practice/level of care that is more appropriate for your clinical needs.
- Patient non-compliance (for example, not following through on an agreed upon treatment plan, frequent no-shows or late cancellations of appointments, misuse of prescription medication, or declining referrals for adjunctive/alternate levels of care) may also result in termination from the practice
- If the decision is made to transfer or terminate your care with the practice, you will be provided with short-term (up to 30 days) treatment while you arrange your transfer of care

Confidentiality

- Exceptions to the requirement for written authorization to release your treatment information include (but are not limited to):
    - Communication with other professionals involved in your care
    - Communication with family members in some circumstances
    - Professional consultation regarding your treatment
    - Phone call/text/email reminders to the contact number and email address you have provided
    - If there is a threat to your own safety or the safety of others
    - Suspected abuse/neglect of a child or elderly person
    - Court proceedings (if required by court order)

If you have any questions, concerns or recommendations about your treatment or about my practice policies, please feel free to communicate those to me. These policies and procedures are subject to change at any time. If you decide to end treatment at any time in the future, please let me know so I can assist you in a follow-up plan.

Acknowledgement of Receipt of Practice Policies and Procedures

I, _____, have received a copy of the Arpan Parikh MD Inc Practice Policies and Procedures. I understand the contents of this document, and agree to abide by these policies. I also understand that I may request a copy of these policies from the practice at any time.

Patient Name: _____

Patient Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below constitutes that I have been offered a copy and had an opportunity to read the *Notice of Privacy Practices of Arpan Parikh MD Inc*. I understand this notice contains a description of the uses and disclosures of my personal health information and agree that my personal health information may be transmitted by computer to laboratories and/or consulting health care practitioners to facilitate my medical care. I understand this information may be updated at any time and I can obtain a current copy from the practice at any time. The policy of this practice is to be in compliance with state and federal medical practice guidelines.

Patient Name: _____

Patient Signature: _____ Date: _____

Arpan Parikh MD Inc
Consent for E-Mail Communication

I, _____, hereby consent to have Dr. Parikh (or his staff) communicate with me or members of his staff, where appropriate, or other physicians, nurse practitioners, and pharmacists via e-mail regarding the following aspects of my medical care and treatment: (test results, prescriptions, appointments, billing, etc.). I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between Dr. Parikh and me or members of Dr. Parikh's staff or between Dr. Parikh and other physicians, nurse practitioners, and pharmacists regarding my medical care and treatment may be intercepted by third parties. I also understand that any e-mail communication between my physician and me or members of his staff, or between my physician and other physicians, nurse practitioners, or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an emergent situation I should call my doctor, call 911, or proceed directly to the nearest emergency room.

Patient Name: _____

Patient E-Mail: _____

Patient Signature: _____ Date: _____

Arpan Parikh MD Inc
ACH/Credit Card Payment Authorization

☒ **One (1) Time Charge** – You authorize the merchant below to make a one-time charge to your Credit Card or Bank Account listed below.

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

I, _____, authorize Arpan Parikh MD Inc to charge my Credit

Card or Bank Account indicated below for **$800** on 6/27/2023 (Date).

Billing Details

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Credit Card Information (3% credit card fee will be added to professional fee)
☐Visa ☐MasterCard ☐AMEX ☐Discover

Cardholder's Name: _____ Credit Card Number: ____-____-____-____

Expiration Date: ____/____ Security Code (CVV): ____

OR:

Bank (ACH) Information
☐- Checking Account ☐- Savings Account

Name on Account: _____ Bank Name: _____

Account Number: _____ Routing Number: _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the merchant in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that the merchant may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions

with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

Individual's Signature _____ Date _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: Arpan Parikh MD Inc to release to:

Ashley Kennedy

(Persons/Organizations authorized to receive the information)

kennedytherapyla@gmail.com

(Address — street, city, state, zip code)

The following information:

a. ☒ All health information pertaining to my medical history, mental or physical condition and treatment received; OR

❑ Only the following records or types of health information (including any dates):

_____

_____

b. I specifically authorize release of the following information (check as appropriate):

☒ Mental health treatment information _____ (initial)

❑ HIV test results _____ (initial)

☒ Alcohol/drug treatment information _____ (initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.[1]

(over)

1 Health care providers that do not maintain psychotherapy notes as defined in HIPAA may wish to delete this sentence.

PURPOSE

Purpose of requested use or disclosure: ❑ Patient request; OR ☒ Other: Care Coordination

Limitations, if any: NONE

EXPIRATION

This authorization expires on *(date)*: 4/5/2023

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing[3] and submit it to the following address: Arpan Parikh MD Inc: arpan@arpanparikhmd.com.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

- I have a right to receive a copy of this authorization.[4]
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless

2 If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

3 Patients of federally-assisted substance abuse programs and patients whose records are covered by LPS may revoke an authorization verbally.

4 Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 C.F.R. Section 164.508(c)(4))*.

another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Date: _____ Time: _____ ☐ AM - ☐ PM

Signature: _____
(patient/legal representative)

If signed by a person other than the patient, indicate relationship: _____

Print name: _____
(legal representative)

NOTES FOR PROVIDERS THAT USE THIS FORM:

- If the purpose of the authorization is to use the information for marketing by a third party that remunerates the provider, a statement to this effect must be included in this authorization form.
- If the purpose of the authorization is for the sale of protected health information (PHI), this form must state whether the PHI can be further exchanged for remuneration by the initial recipient.
- A provider that discloses health information pursuant to an authorization must communicate any limitation contained in the authorization to the recipient [Civil Code Section 56.14]. The required notification may be accomplished by giving the recipient a copy of the authorization form.