NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

REGISTRATION

Patient ____
Last Name **First Name** **Middle Initial**

Street Address ____

City ______________________ **State** ________ **Zip** ________-______

Phone Numbers: Home- ________________ **Work:** ________________ **Cell:** ______________

Sex:__________ **Identified Gender:**______________ **Age:** ________ **Birth Date** ______________

E-mail: ________________________________

Race: □ **White** □ **Black** □ **Asian** □ **Other** _______ **Ethnicity** __________ **Preferred Language** __________

Emergency contact __________________ **Phone #** ________________ **Relationship** ________

If patient is a minor or has a legal representative or guardian, please fill out the information below.
(Guardian/Legal Representative is required to attach supporting legal documentation)

Responsible Party ____

Street Address (if different from patient) ______________________________

City ______________________ **State** ________ **Zip** ________-______

Date of Birth ____________ **Phone Number** ___________ **E-mail** ____________________

Insurance Information

1. Primary Insurance ____

Policyholder Name ______________________ **Relationship to Patient** ________________

Date of Birth ____________ **Policy #** ______________________ **Group #** __________

2. Secondary Insurance ____

Policyholder Name ______________________ **Relationship to Patient** ________________

Date of Birth ____________ **Policy #** ______________________ **Group #** __________

√ **Can we leave a text or message at the phone number provided with family member/s or on the voicemail for appointment reminders or other information? – Yes No**

Name:____________________ **Signature** __________________ **Date:**__________

NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

ASSIGNMENT/RELEASE/CONSENT TO TREATMENT

Patient Name ____ **Date of Birth** _____/_____/_______

(All patients/guardians sign below)

I authorize and request treatment/s from **RAVI KANT, M.D**. and/or his associates to perform routine diagnostic procedures and to provide medical treatment as is medically necessary in his/their professional judgment.

I hereby authorize release of protected health information, including mental health and/or substance abuse (drug and alcohol), necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me to **RAVI KANT, M.D. PC** as indicated on the insurance claim form. I understand that this facility and its providers are mandated reporters of any and all suspected or witnessed child abuse and/or neglect. (Section 6383 (b) of Title 23 of the Pennsylvania Consolidated Statutes/Act of July 1, 2015, P.L. 94, No. 15). I also understand that I am financially responsible for any balance not covered by my insurance carrier(s) (including but not limited to deductibles and/or co-payments) and agree to pay the full charges if payment is/are denied by my insurance carrier(s) for any reason or if no insurance coverage exists at the time of services. It is my responsibility to update any changes in insurance. I understand it is mandatory to notify the health care provider of any other party who may be responsible for payments (section 1128 B, Social Security Act and 31 U.S.C. 3801- 3812 provides penalties for withholding this information). Medicare regulations apply. I have received, read and agree with the billing and other office policies.

With my consent, Ravi Kant, M.D., his associates, and office staff can call my home and leave messages on an answering machine or with a person, text, or e-mail me regarding appointments and contact the designated emergency contact person if needed. I may revoke my consent in writing except to the extent that the practice has already acted upon in reliance upon my prior consent. If I do not sign this consent, Ravi Kant, M.D. and his associates may decline to provide services to me. I agree with the above.

All the information provided in this Registration-Assignment/Release/Consent to Treatment is true and current.

Notice of Health Information Practices - Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the above Notice of Health Information Practices. I recognize that this is a federal mandate that this facility must comply with. Patient Initials _____

Notice of Patient Rights and Responsibilities - Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the Patient Rights and Responsibilities provided at the office. Patient Initials _____

Notice of Grievance Procedure – Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the Grievance Procedure provided at the office. Patient Initials _____

Patient Signature ____ Date _____________
(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name ____

Responsible Party Signature ____ Date _____________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ___________________________________
(Guardian/Legal Representative is required to attach supporting legal documentation)

Office use only
Witness ____________________________Name ______________________________ Date _________________

NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

OFFICE POLICIES

Patient Name ____ **Date of Birth** _____/_____/_______

Insurance Coverage:
Due to frequent changes in insurance coverage (benefits, exclusions, deductibles and/or prescription coverage, etc.), we cannot inform or advise you about your benefits. In some insurance policies, certain diagnoses may be excluded, such as ADHD, Autism, Mental Retardation and related conditions. We do not routinely do the paperwork for non-formulary medicines not covered by your insurance company. You are responsible for keeping track of number of visits allowed in your plan and how many visits you have used with your therapist and prescriber. You will be charged for additional visits. If you do not have insurance coverage, you are responsible for the full charges. Please inquire in advance about our charges if you do not have insurance.

Payments:
It is our policy to collect all **co-payments and/or deductibles** at the time of service unless arrangements are made ahead of time.
We accept checks, cash, and debit or credit cards (Visa, MasterCard American Express or Discover).

A service charge of **$10.00** plus interest (1.5%/month) will be added to any outstanding balance over 30 days past due. Also, all delinquent accounts (over 90 days past due) may be turned over to a collection agency. An additional **$40.00** as a handling fee and the costs of collection (including attorneys' fees and costs) will be added to the total amount due.

Attendance Policy:
We understand that it is not always possible to keep a scheduled appointment or give 24 hours notice of cancellation. If a pattern of same day cancellation or "No Shows" develop, we reserve the right to bill you **$50.00** fee for the missed appointment time. Your insurance company is not responsible for this charge. Prescriptions may not be called in for No Show or Canceled appointments. Additionally, if there are frequent No Show for appointments or non-compliance with treatments, you may be discharged from the practice.

Lost Prescription Fee:
A service fee of **$20.00** will be charged to replace lost scripts. Scripts will need to be picked up from the office after payment of the fee.

Returned checks – Fee of **$40.00** will be charged for checks returned for any reason.

****Fees may be changed without notice.**

I have read and agree to be legally bound by the terms of these office policies including the financial responsibility provisions hereof. I understand that I am financially responsible for any amounts not covered or paid by my insurance carrier and that I am responsible for providing current insurance information and inform the office of any address and/or insurance changes.

Patient Signature ____ Date ______________
(If patient is a minor (ages 14-18), he/she must sign this Office Policy Form)

Print Name ____

Responsible Party Signature ________________________________ Date ______________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ________________________________

(Guardian/Legal Representative is required to attach supporting legal documentation)

Office Use Only
Witness ______________________ Name ______________________ Date ______________

NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:____________________ **Date of Birth:**____________________
Phone Number:____________________ **Email:**____________________

I consent to and authorize to disclose my protected health information relating to my identity, diagnoses, prognosis, and/or treatment. These records may include information related to medical conditions, tests, mental or behavioral health, substance abuse (drug and alcohol), and HIV-related. These records are called protected health information and are protected by federal and/or state law.

From: Ravi Kant, MD, P.C.
(Name and address of provider or facility releasing records)

To: PCP Family Member Other Medical Provider Other__________

Name: ____________________
Address: ____________________
Phone Number:____________________
Fax Number: ____________________

The purpose for this disclosure is: Coordination of Care Disability Application Other__________

I understand that the specific types of records to be released (identify all records or all that apply) are:

All records including psychiatric/psychological evaluation Scheduling appointments/Medication refills
Insurance claims and payments only Other____________________

****Mental or behavioral health, substance abuse, and HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.****

DO NOT RELEASE: Mental/Behavioral Health (Psychiatric) HIV-Related Substance Abuse (Drug and Alcohol)

I understand that this authorization is revocable upon my written request and that this consent will remain in force unless revocation from the patient or legal guardian is received. I also understand that any revocation of this authorization must be in writing and sent or delivered to my health care provider's office. I also understand that my decision to revoke this authorization may result in my insurance company not being able to pay for my medical care and I will be liable for payment for the services rendered.

Patient Signature ____________________ **Date** __________
(If patient is a minor (ages 14-18) he/she must sign this Authorization for Release of Protected Health Information Form)

Print Name ____________________

Responsible Party Signature ____________________ **Date** __________
(Parent/Guardian/Legal Representative)

Print Name ____________________

Relationship to Patient ____________________
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only
Witness _______________ Name _______________ Date _______________

NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

Patient Name: ____ Date of Birth: _____/_____/_______

Parent/Legal Guardian Name: ____________________________________ Relationship_________________

By signing below, I permit NeuroPsychiatry Center to communicate protected health information for the above patient via e-mail at__________________________________@___________________.________

E-MAIL RISKS AND YOUR RESPONSIBILITY:

You and your provider/s at NeuroPsychiatry Center (NPC) and its employees and staff have agreed to correspond using e-mail. These e-mails may contain personal protected health information including, mental health issues. You need to be aware of the risks and your responsibilities.

A.) As the internet is not secure or private, unauthorized people may be able to intercept, read, and possibly modify e-mail/s you send or receive from NPC. You must protect your e-mail account and password against unauthorized use. Hackers can get access to your account.
B.) Viruses can be spread via e-mail and some may cause e-mail messages to be sent to unintended people.
C.) E-mails can be copied, printed, and forwarded by recipients; be careful with whom you send or share e-mails.

1. CONDITIONS FOR THE USE OF E-MAIL:

By consenting to the use of e-mail with NPC you agree that:

A.) NPC may forward e-mails, as appropriate, for diagnosis, treatment, billing, and other related reasons. Employees and medical staff other than the intended recipient may have access to your e-mails.
B.) Although NPC will try to read and respond to your e-mail, we may not read your e-mail immediately. If you do not receive a response within a reasonable time, it is your responsibility to contact us to follow up.
C.) You should carefully consider the use of e-mail for the communicating sensitive medical and personal information.
D.) E-mail messages should be **short, clear, and concise**.
E.) NPC reserves the right to save your e-mail including the information contained there in the medical records.
F.) You agree not to abuse the right to communicate with your physician's office and your communications will be professional in content.
G.) E-mail access to staff is being provided as a convenience to our patients and NPC has the right to restrict your ability to communicate with us via e-mail at any time for any reason, including cases where NPC reasonably believes that it is not in your best interest to continue to seek advice via e-mail and an in person appointment is needed or that e-mail is being used excessively in lieu of in person care.

2. INSTRUCTIONS:

A.) You should immediately inform the staff at NPC of any changes in your e-mail address.
B.) **E-mail should be used only for non-sensitive and non-urgent issues such as prescriptions, scheduling, general questions or advice. E-mail is not a substitute for psychotherapy or medication management appointments.**
C.) Please put the patients name and date of birth in the body of the e-mail for proper identification.
D.) If you wish to withdraw your consent to communicate via e-mail, you must inform NPC in writing.

NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

ACKNOWLEDGEMENT AND AGREEMENT

NeuroPsychiatry Center will use reasonable means to protect the privacy of the patient's health information. However because of the risks outlined above, NPC cannot guarantee e-mails will be confidential. Also NPC will not be liable in an event that you or anyone else inappropriately uses or accesses your e-mail. NPC will not be liable for improper disclosure of your health information that is not caused by our intentional misconduct.

NPC is not responsible for e-mail messages that are lost due to technical failure during composition, transmission and/or storage. NPC may impose restrictions to communicate with me by e-mail. I have read and understand the information above, and had any questions answered to my satisfaction. I have received the copy of this consent form. I agree to the guidelines for e-mail communication. I understand that this consent is valid until such time as I revoke the consent outlined above, except to the extent that a staff has already acted in reliance upon this authorization.

Patient Signature ____ **Date** ____________________
(If patient is a minor (ages 14-18) he/she must sign this Release of Protected Health Information via Electronic Communication Form)

Print Name ____

Responsible Party Signature ____________________________________ **Date** ____________________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

DO NOT SEND E-MAIL FOR EMERGENCIES

GO TO THE NEAREST HOSPITAL, CALL 911, OR CONTACT YOUR COUNTY'S EMERGENCY CRISIS NUMBER

We will not read e-mails on weekends, holidays, or when on vacation.

Office Use Only

Witness ____________________________ Name ______________________ Date ______________________

NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

PRESCRIPTION REFILL POLICIES AND PROCEDURES

Patient Name: ____ **Date of Birth:** __________________

Parent/Legal Guardian Name: __________________________________ **Relationship**____________________

In order to make the prescribing medication and requesting temporary refills process efficient, we will follow the procedures listed below. Patients or a parent/legal guardian should initial and sign below.

● Check which medications need refilled before coming to your appointment. It is **YOUR** responsibility to get your medications refilled during your visit. Schedule your next visit at least **1 week prior** to running out of your current refill(s).

● If you require a medication refill in-between scheduled appointments, it is **YOUR** responsibility to request it from our website - www.drkant.com and fill in the "Medication Refill Request" online. Refill requests are **NOT** accepted via phone. We need at least **72** hours notice (excluding weekends or holidays) to respond to your request. Please note that we do **NOT** accept medication refill requests from pharmacies.

I understand the above: X_________________

● Regular office visits are required for monitoring and prescribing medications as determined by your provider. Medications will not be called in without required office visits.

I understand the above: X_________________

● Blood work is needed for some medications to assess the safety and effectiveness. For patients who do not get the blood work done in a timely fashion, we will refuse to fill their prescriptions.

I understand the above: X_________________

● If prescribed a controlled substance as identified by the DEA, per office policy, patients must be seen at least every 4-8 weeks, at the discretion of the provider. Refills for controlled substances will only be provided during appointments. Random urine screens may be requested to assess the use of narcotics or abuse of illicit drugs.

I understand the above: X_________________

I have read the **Prescription Refills Policies and Procedures** and by initialing above and signing below, I agree to abide by them in full and have been given a copy if requested.

Patient Signature ____ **Date** ________________________
(If patient is a minor (ages 14-18) he/she must sign this Prescription Refill Policies and Procedures Form)

Print Name ____

Responsible Party Signature ____ **Date** ________________________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only
Witness ______________________________ Name ________________________ Date _________________________

NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

E-PRESCRIBING MEDICATION HISTORY CONSENT

Patient Name ____ **Date of Birth** _____/_____/_______

I understand that NeuroPsychiatry Center utilizes e-prescribing. I understand that e-prescribing allows the practice to send prescriptions electronically to pharmacies, eliminating the need for prescribing via paper, phone, or fax. E-Prescribing is fast, convenient, legible, secure, cost-effective and safe. In some cases, it also allows the health care provider to access critically important information about patient's current and past medications from pharmacy benefit managers and community pharmacies. This helps to alert the provider to other potential medication interactions or if patient is getting same or similar medications from multiple providers.

I have been given an opportunity to ask questions about the e-prescribing process and have had those questions answered to my satisfaction. I hereby consent to the practice requesting and using my medication history from other health care providers, pharmacies, or third party pharmacy benefit payers for treatment purposes.

Patient Signature ____ **Date** ____________________
(If patient is a minor (ages 14-18) he/she must sign this Authorization for E-Prescribing Medication History Consent Form)

Print Name ____

Responsible Party Signature ___________________________________ **Date** ____________________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only

Witness _________________________ Name ____________________ Date ____________________

Ravi Kant, MD, P.C. NeuroPsychiatry Center

300 Old Pond Rd., Suite 201, Bridgeville, PA 15017 Tel. 412-220-7323

Name ____ DOB ______/______/______ Date_________

PERSONAL CRISIS PLAN

My Trigger**s:**____

____

Thoughts/Inside Warnings:____

____

Outside Warning Signs:____

____

When Notice My Triggers I will:____

____

When Others Notice I'm Upset I'd like them to:______________________________________

____

Things That Help Me Stay Better Now:____

____

Things That Help Me Stay Well on a Regular Basis:___________________________________

____

Things That Make Me Feel Worse:____

____

*If I'm feeling unsafe, I will go to the ER of local hospital, call Suicide Hotline 1-800-273-8255, or call my county's crisis number.

Patient Signature ____ Date ______________
(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name ____

Responsible Party Signature _______________________________________ Date ______________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative is required to attach supporting legal documentation)

Office use only
Witness ____________________________Name ______________________________ Date _________________