**Ravi Kant MD PC**

300 Old Pond Road, Suite 201, Bridgeville, PA 15017

**ASSIGNMENT/RELEASE/CONSENT TO TREATMENT**

**Patient Name** _____ **Date of Birth** _____

Phone #_____ Email Address_____ SSN #_____

Age_____ Sex Assigned at Birth_____ Identified Gender_____

Race: □ White □ Black □ Asian □ Other Ethnicity_____ Preferred Language_____

Emergency Contact Name_____ Emergency Contact Phone #_____ Relationship_____

Address_____

Primary Insurance_____ Policy Holder_____ DOB_____

Relationship to patient _____ Policy #_____ Group # _____

Secondary Insurance_____ Policy Holder_____ DOB_____

Relationship to patient _____ Policy #_____ Group # _____

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 the 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. If I do not sign this consent, Ravi Kant, M.D. and his associates may decline to provide services to me. All the information provided in this Registration-Assignment/Release/Consent to Treatment is true and current. I understand that payment of a claim may be from federal and/or state funds. Any false claims, documents, or concealment of material facts may be prosecuted under applicable laws.

**Notice of Health Information Practices -(Copy is posted in office for your review or can 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. ✓

**Notice of Patient Rights and Responsibilities -(Copy is posted in office for your review or can download at drkant.com)**

I have read and understood the Patient Rights and Responsibilities provided at the office. ✓

**Notice of Grievance Procedure -(Copy is posted in office for your review or can download at www.drkant.com)**

I have read and understood the Grievance Procedure provided at the office. ✓

(If the patient is a minor (ages 14-18) he/she must sign this consent)

**Patient / Guardian name**_____

**Relationship to the patient**_____

**Signature**_____ **Date**_____

## Ravi Kant MD PC

## OFFICE POLICIES

***PLEASE REVIEW THIS INFORMATION CAREFULLY AND KEEP A COPY FOR YOUR FUTURE REFERENCE***

**Insurance Benefits and Payment for Services**

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. You should contact your insurance company with any questions about your benefits. If you have more than one health insurance policy or some other type of third-party benefits, or changes to your policy, it is your responsibility to ensure that our office has the most updated information at the time of your appointment. If you do not have health insurance coverage, you are responsible for the full charges. Please inquire in advance about our charges if you do not have insurance.

**Good Faith Estimates:**

Under federal law, health care providers need to provide patients who do not have insurance or who are not using insurance with an estimate of the bill for medical items and services. You have the right to receive a "Good Faith Estimate" for the total expected cost of any non-emergency items or services. You can ask our office staff for a "Good Faith Estimate" prior to the scheduling of an appointment. Make sure to save a copy of your estimate. For questions or more information about your right to a "Good Faith Estimate," visit www.cms.gov/nosurprises **Payment Policy:**

It is our policy that all payments, including insurance deductibles, self-pay fees, co-payments, etc. are collected at the time of service unless arrangements are made ahead of time. We accept checks, cash, and debit/credit cards (Visa, MasterCard, American Express, or Discover)

A service charge of **$10.00** plus interest of 1.5%/month may be added to any outstanding balance over 30 days past due. Any account with an outstanding balance more than 90 days past due, without any payment arrangements approved by our office, will be sent to a Collections Agency. An additional **$40.00** will be charged to the account, covering a handling and processing fee, fees charged by the Collections Agency, and any other necessary costs and expenses, such as reasonable attorney fees.

Additional fees may be incurred for other services including but not limited to phone consultations, reproducing medical records, and completing requested reports or documents (e.g. FMLA forms, letters for school or employment, workers compensation claims/forms, or disability claims/forms, etc.). Please contact our office for current related charges. Please note that requests for records and/or documentation may take up to 30 days to be processed.

**Returned Checks:**

You will be charged a fee of **$40.00** for any returned checks.

**Credit Card Policy:**

Our office **requires** all patients to have a credit card on file. The Credit Card Authorization Form included with this packet must be completed. In lieu of the included form, you can request that office staff send you a link for an encrypted form. Charges to your credit card will be for any applicable co-payments, deductibles, self-pay fees, late cancellation, no-show fees, if your insurance policy denies payment for any reason/s for the services that were provided, etc. Charges to your credit card will occur automatically after services are provided. If a charge exceeds $500.00, the office staff will notify you of such charges at least two business days in advance of the card on file being charged. In case of any payment disputes, you are responsible for all credit card fees incurred by the practice.

This policy does not apply to medical assistance recipients.

**Late Cancellation and Missed Appointment Policy:**

We understand that it is not always possible to keep a scheduled appointment or give 48 hours' notice of cancellation. For any cancellation given under 48 hours' notice (not counting weekends or holidays) or any missed appointment, you may be charged the following fees:

- New Patient appointment cancellation under 48 hours (excluding weekends or holidays) or missed appointment **$100**
- Current patients - appointment cancellations under 48 hours (excluding weekends or holidays) or missed appointments - **$75**

Your insurance company is not responsible for Cancelled or Missed appointment fees. Such fees will be charged to your credit card on file. Text, email or phone appointment reminders are provided as a courtesy to assist you in managing your schedule and keeping your appointment. If you arrive late by ten minutes or more to an appointment, then your appointment may be rescheduled, and a Missed Appointment fee may be charged. This policy does not apply to medical assistance recipients.

**We reserve the right to terminate treatment due to repeated failure to comply with treatment recommendations.**

**Frequent Cancellations Under 48 hours and/or Missed Appointments, outstanding balances, or inappropriate behaviors. Every effort will be made to discuss such treatment concerns with you before services are discontinued.**

**E-Prescribing Medication**

I understand that the practice utilizes e-prescribing. E-Prescribing is fast, convenient, legible, secure, and safe. In some cases, it also allows health care providers to access critically important information about patient's current and past medications from pharmacy benefit managers and community pharmacies. This may help to alert the provider to potential medication interactions or if a patient is getting the same or similar medications from multiple providers. All medication providers are required to check the prescription drug monitoring program (PDMP) established by the State for controlled medication prescriptions.

**Medication Refills and Lost Prescriptions:**

Medications will only be prescribed at scheduled appointments. If a prescription is lost, misplaced, stolen, or finished sooner than prescribed, your prescription(s) will not be replaced until the appropriate time as determined by your provider. Medication will not be provided in between appointments. There may be rare exceptions to this policy at the discretion of your provider, and a **$25/**medication fee (depending on the complexity of the completion of the refill) may be required before the refill is processed. (This fee does not apply to Medicaid recipients). Medication refills may not be sent if you have an overdue outstanding balance on your account. Refills for controlled substances will only be provided during appointments. Random urine drug screens may be requested to assess the use of narcotics or abuse of illicit substances.

***We need at least 72 hours' notice (excluding weekends or holidays) to respond to your request.***

****Please note we do not accept medication refill requests from pharmacies ****

****You must request the refill from your MYIO Patient Portal** After-Hours**

**Services:**

This office does not provide 24-hour care. After hours, please use our on-call service by calling the office phone number and follow the prompts. The answering service should only be used for urgent matters. If you are having an emergency and you are not able to reach your provider, you should immediately proceed to the emergency room of the nearest medical facility or call 911.

**Email and Text Messages Consent**

I consent to communicate with the office (providers, admin staff and its affiliates) by email and text messages. These messages may contain personal protected health information including mental health and substance abuse issues. You need to be aware of the risks and your responsibilities.

As the internet is not fully secure or private, unauthorized people may intercept, read, and possibly modify messages you send to or receive from us. You must protect your accounts and passwords against unauthorized use. Hackers can get access to your account and send inappropriate/unauthorized messages on your behalf. Viruses and Malwares can be spread via email causing damage to your equipment, online accounts, and passwords. Messages can be copied, printed, and forwarded by recipients; be careful about who you send messages to. Be very careful about clicking any links in the messages if you are not expecting such or from any unknown senders.

The Ravi Kant MD PC will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, we cannot guarantee that your messages will be completely confidential. You agree not to hold Ravi Kant MD PC liable in the event if any unauthorized person inappropriately using or accessing your messages or for improper disclosure of your health information that is not caused by our intentional misconduct.

Ravi Kant MD PC is not responsible for emails/text messages that are lost due to technical failure during composition, transmission and/or storage. We may impose restrictions on you to communicate with us by email/text messages. I understand that this consent is valid until such time till I revoke it in writing, except to the extent that a member of staff has already acted in reliance upon this authorization. With my consent, Ravi Kant, M.D., his associates and office staff may contact the designated emergency contact person, if needed.

**DO NOT SEND EMAILS FOR EMERGENCIES. IN SUCH CASE, GO TO THE NEAREST HOSPITAL ER, CALL**

**911 OR CONTACT YOUR LOCAL EMERGENCY CRISIS NUMBER.**

***Your providers will not read emails on weekends, holidays, or when on vacation. ***

I have read this document in its entirety. By signing below, my signature indicates that I have read or heard information and agree to the office policies defined here and consent to receive the psychiatric services from Ravi Kant MD PC. I understand that these policies may change in the future without any prior notice. If consenting on behalf of another person, please indicate relationship to the patient: **(If patient is a minor (ages 14-18) he/she must sign this Office Policies Form)**

**Patient / Guardian name**_____

**Patient's date of birth**_____

**Relationship to the patient**_____

**Responsible Party** _____

(If the patient is a minor (ages 14-18) he/she must sign this consent)

**Signature**_____ **Date**_____

## Ravi Kant MD PC Telehealth Information and Consent

Patient Name_____ DOB_____

**Introduction:**

**Telehealth is the delivery of medical or mental health services using interactive video conferencing or a telephone call (when permitted), that enables a provider at a distant location to provide treatment to me. I understand that this consultation will not be the same as a direct in office visit. Telehealth will allow me to receive medical care without the need to visit the office and travel long distances. I understand that my insurance may not cover telehealth services. If my insurance does not cover telehealth services, I agree that I will be responsible for self-pay charges for the visit. I am aware that during my telehealth appointment, it is important to be in a private location for the duration of the appointment. I acknowledge that the telehealth sessions will not be recorded by either party. In the event of a transmission failure, I am aware of the contingency plan. I am aware that I can refuse services via telehealth and that such refusal will not be used as a basis to limit access to other available services. Alternatives to telehealth services may possibly cause delays in service/s due to scheduling issues, need to travel, and/or risks associated with not having the services provided by telehealth. The interactive electronic systems used in telehealth are known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. Our practice currently uses HIPAA compliant telehealth platforms. We may use the landline telephone for audio to enhance the security of the information being discussed.**

**During the telehealth consultation-**

1. **Details of my medical history, current medications, and results of medical tests will be discussed.**
2. **Non-medical personnel may be present to assist in operating conferencing equipment, if needed.**
3. **At times students may be present during the session. I will be informed about who is present in the office.**

**Potential benefits:**

- **Patient convenience - Increased accessibility to psychiatric care Potential**

**Risks:**

**As with any medical procedure, there may be potential risks associated with the use of telehealth. These risks include, but may not be limited to:**

- **The information transmitted may not be sufficient (e.g., poor resolution) to allow for appropriate medical decision making by your provider.**
- **Your provider may not be able to provide treatment to me using interactive Audio-Video equipment nor provide for or arrange for emergency care that I may require.**
- **Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.**
- **Security protocols can fail, causing a breach of privacy of my confidential medical information.**
- **A lack of access to all the information that might be available in a face-to-face visit but not in a telehealth session may result in errors in medical judgment.**

**Alternatives to the use of telehealth: - Traditional face-to-face sessions in the office**

**My Rights:**

- **I understand that the laws that protect the privacy and confidentiality of medical information also apply to telehealth.**
- **I understand that the technology used by the providers is encrypted to prevent unauthorized access to my private medical information.**
- **I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.**
- **I understand that my providers have the right to withhold or withdraw approval for the use of telehealth during my care at any time.**
- **I understand that all rules and regulations which apply to the practice of medicine in the state of Pennsylvania also apply to telehealth services.**

**My Responsibilities:**

- **I will not record any telehealth sessions without written consent from Dr. Kant or his associates. I understand that my providers will not record any of our telehealth sessions without my written consent.**
- **I will inform my providers if any other person can hear or see any part of our session before the session begins. My providers will inform me if any other person can hear or see any part of our session.**
- **I understand that I, not my providers, am responsible for configuring all equipment used on my computer for telehealth. It is my responsibility to ensure the proper functioning of all equipment before my session begins.**
- **I must be a resident of the state of Pennsylvania or any other state where Dr. Kant holds a valid medical license to be eligible for telehealth services from my providers.**
- **I understand that my initial evaluation may not be done by telehealth except in special circumstances under which I will be required to verify my identity to provider satisfaction before the evaluation.**

**Telehealth Video Instructions:**

1. **Log into your MYIO Patient Portal Account via the app or this link https://valant.io/myio/RaviKantMDPC**
2. **Click on your appointment and click "Check-In". Click "I'm ready, check me in"**
3. **Click on the "Join Now" button to begin your telehealth session.**

**I have read and understand the information provided above regarding telehealth, I have discussed it with Dr. Kant or his associates, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth for my medical care and authorize Dr. Kant or his associates to use telemedicine in the course of my evaluation, diagnosis and treatment. If for any reason/s, telehealth is not considered appropriate for my treatment by my provider/s, then I will need to come to the office for ongoing treatments.**

(If the patient is a minor (ages 14-18) he/she must sign this consent)

**Patient / Guardian name**_____ _____

**Relationship to the patient**_____

**Signature**_____ **Date**_____

Credit Card Authorization

**Ravi Kant, MD, P.C.**

**300 Old Pond Road, Suite 201, Bridgeville, PA 15017**

Please complete all the fields. You may cancel this authorization at any time by contacting us in writing. This authorization will remain in effect until cancelled.

**Patient Name:**_____ **Patient Date of Birth** _____

Cardholder's Name - Last_____ First _____ Card

type – Visa___ MC ___ AmEx ____ Discover _____

Last 4 digits of Credit Card _____ Exp Date _____(mm/yr) CVV _____ Billing

Zip Code_____

Please call the office to give full credit card info or add it at your **MYIO App** account

I hereby authorize **Ravi Kant MD PC dba NeuroPsychiatry Center** to charge my credit card listed above or entered in the portal account for services provided to my family member/s, dependents and/or myself. This can include self-pay fees, co-payments, deductible, No-Show and/or late cancellation fees, and services not covered under my insurance, but I agreed to receive. I understand my credit card will not be charged more than $500 at one time. I understand that my information will be saved on file for future transactions on my account. I am responsible for keeping this information updated in a timely manner. This authorization will apply to any credit card updates in the future. I am aware that NeuroPsychiatry Center will be unable to notify me before processing this card on file and that my card may be charged at any time at the discretion of NeuroPsychiatry Center for the reasons listed above. I will be responsible for any and all associated credit card fees if I cancel the payments charged through my bank or credit card company.

These circumstances DO NOT apply to medical assistance recipients.

I certify that this data is true, correct & accurate. Any false claims, documents, or concealment of material facts may be prosecuted under applicable laws. Under penalty of perjury, I herewith affirm that my electronic signature, and all future electronic signatures, were signed by myself with full knowledge and consent and am legally bound to these terms and conditions.

**Patient/Guardian/Responsible party signature**

**Sign *X**_____ **Date:**_____

PERSONAL CRISIS PLAN

**Ravi Kant, MD, P.C.**

**300 Old Pond Road, Suite 201, Bridgeville, PA 15017**

My Triggers:_____

_____

Thoughts/Inside Warnings: _____

_____

Outside Warning Signs: _____

_____

When I 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 the local hospital, call the Suicide Hotline at 1- 800-273-8255, or call my county's crisis number. ✓

**Patient / Guardian name_____**

**Relationship to the patient_____**

**Signature_____ Date_____**

(If patient is a minor (ages 14-18) he/she must sign this Crisis Plan)

# Ravi Kant, MD, P.C. NeuroPsychiatry Center

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

Name _____

DOB ____/____/____ Age_____

Parents/Legal Guardians _____ ** If minor is not living with both parents or minor has a legal guardian, a legal custody agreement MUST be provided in order for the minor to be seen. **

***If patient is under the age of 14 years, please have ALL parents/legal guardian(s) sign consent for treatment documentation as well as release of information****

**You will be responsible for full payment if your insurance company denies payment for any reasons***

**Co-Payments are due at each visit. Bring all relevant medical records with you. (No X-Ray)***

| Current healthcare providers | Address | Phone | Fax |
|---|---|---|---|
| **General Practitioner:** | | | |
| **Therapist/Psychologist:** | | | |
| **Other Health Care Provider:** | | | |

**Who can we thank for recommending our practice?** _____

**Current Pharmacy**: Name _____ City _____ Zip _____ Phone _____

**Allergies:** Y N If yes what?

Reaction(s) _____

**Height** - _____ **Weight** _____

**Chief Complaints** (Please circle)

| | | | | | |
|---|---|---|---|---|---|
| Depression | Y | N | Psychosis | Y | N |
| Anxiety | Y | N | Attention/Concentration | Y | N |
| Panic Attacks | Y | N | Eating Disorder | Y | N |
| Hypomanic/Manic Episodes | Y | N | Drugs/Alcohol | Y | N |
| Anger | Y | N | | | |
| Other: _____ | | _____ | _____ | | |

**Current stressors** (Please circle)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| School | Y | N | Social | Y | N | Family | Y | N |

Medical Y N Pain/Disability Y N Work/Job Y N

Other:

Describe in your own words your current symptoms

**History**

When did your symptoms start? ____Years or ____ Months ago Have you had similar symptoms in the past? Y N

What, if any, triggered the symptoms? _____

What has been helpful to control the symptoms? _____

**Mood Symptoms:**

**Circle the appropriate answer, then rate IF YES:** ***(Rate symptoms on scale of 0 to 10; 0 good, 10 worse)***

| | | | |
|---|---|---|---|
| Depression | Y | N | 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 |
| Mania/Hypomania | Y | N | 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 |
| Anger/Irritability | Y | N | 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 |

**Depression:**

| | | | | | |
|---|---|---|---|---|---|
| Irritability | Y | N | | | |
| Tearfulness | Y | N | | | |
| Loss of Interests/ Motivation | Y | N | | | |
| Decreased Appetite | Y | N | Weight loss | Y | N How much |
| Increased Appetite | Y | N | Weight gain | Y | N How much |
| Difficulty falling or staying asleep | Y | N | Total Hours of Sleep per day | | _____hrs. |
| Fatigue | Y | N | | | |
| Negative Thoughts | Y | N | Self-Injury | Y | N |
| Low Self Esteem | Y | N | Suicidal Thoughts | Y | N |
| Social isolation | Y | N | Thoughts of Death/Dying | Y | N |
| Feeling Worthless | Y | N | | | |
| Feeling Hopeless/Helpless | Y | N | Access to firearms | Y | N |
| Homicidal Thoughts | Y | N | If yes, is firearm in secure location? | Y | N |

**Would you reach out to someone if you feel strongly suicidal? Y N** Who? _____

**(You can call ER of local hospital / Suicide Hotline 1-800-273-8255 / Resolve Crisis Hotline 1-888-796-8226)**

**Hypomania/Mania:**

**Has there ever been a period of time when you were not your usual self and:**

Excessive Worrying Y N How often? _____ _____

If yes give examples _____ _____ _____

_____ _____ _____

_____ _____ _____

| | | | | | |
|---|---|---|---|---|---|
| Do you find it difficult to control the worry? | Y | N | Bothered by Crowds | Y | N |
| Restlessness | Y | N | Avoid Going Places | Y | N |
| Fatigue | Y | N | Social Isolation | Y | N |
| Irritability | Y | N | Muscle Tension | Y | N |
| Difficulty falling or staying asleep | Y | N | | | |

**Panic Attacks:** Y N How often? _____

Duration? _____ Where? _____

Triggers? _____ _____

**Panic Attack Symptoms:**

| | | | | | |
|---|---|---|---|---|---|
| Palpitations | Y | N | Nausea | Y | N |
| Chest pressure | Y | N | Fear of Dying | Y | N |
| Sweating/Chills | Y | N | Dizziness | Y | N |
| Shakiness | Y | N | Numbness/Tingling | Y | N |
| Out of Breath | Y | N | Fear of Losing Control | Y | N |
| Feelings of Choking | Y | N | Fear of Being Trapped | Y | N |

| | | | | |
|---|---|---|---|---|
| Obsessions | Y | N | Describe: | _____ |
| Repetitive Behaviors | Y | N | Describe: | _____ |
| Fears | Y | N | Describe: | _____ |
| Flashbacks | Y | N | Describe: | _____ |
| Nightmares | Y | N | Describe: | _____ |
| Delusions | Y | N | Describe: | _____ |
| Paranoia | Y | N | Describe: | _____ |
| Hallucinations | Y | N | Describe: | _____ |

| | | |
|---|---|---|
| You were much more talkative? | Y | N |
| You had much more energy? | Y | N |
| You were more social or outgoing than usual? | Y | N |
| You did things that were unusual or that other people might have thought were excessive, foolish or risky? | Y | N |
| You spent excessive amounts of money or got your family into trouble? | Y | N |

**Anxiety:**

_____

**Cognitive Symptoms**

Long Term Memory: Intact----------Impaired a Little----------Impaired a Lot

Short Term Memory: Intact----------Impaired a Little----------Impaired a Lot

| | | | | | |
|---|---|---|---|---|---|
| Make Careless Mistakes | Y | N | Forgetful | Y | N |
| Difficulty Sustaining Attention | Y | N | Easily Confused | Y | N |
| Easily Distracted | Y | N | Word Finding Difficulties | Y | N |
| Fail to Finish Tasks | Y | N | Difficulties with Info. Processing | N | Y |
| Frequently Lose Things | Y | N | Restless/Fidgety | Y | N |
| Impulsive | Y | N | Intrusive and interrupting often | Y | N |
| Reading | Y | N | Math | Y | N |
| Issues with classroom behaviors | Y | N | Concerns from teachers | Y | N |
| Normal Hearing | Y | N | Normal Vision | Y | N |

If no, please describe: _____

**Physical Changes (If Yes, Describe Symptoms and Identify Treatment)**

Do you suffer from any physical symptoms? (Ex: headaches, nausea, severe PMS, etc) Y N

If yes please describe: _____

_____

_____

_____

**Past Psychiatric History**:

Out Patient Treatments (where and for what reason): _____

_____

Inpatient Treatments (where and for what reason): _____

_____

Therapists/Psychiatrist(s) seen: _____

_____

Medications tried in the past: _____

_____

History of suicide attempt(s)? Y N

If yes provide details: _____

_____

**Family History:**

Medical problems Y N If yes, who? _____

_____

Diagnosis: _____

Emotional problems Y N If yes, who? _____

_____

Diagnosis: _____

Alcohol/Drug Abuse Y N If yes, who? _____

_____

Describe: _____

**Patient's Past Medical History**

Diabetes Y N High Blood Pressure Y N Neurological Disorders Y N

Fibromyalgia Y N Seizures Y N High Cholesterol Y N

Hypothyroidism Y N

Other _____ _____

Surgeries Y N Please describe: _____ _____

Hospitalizations Y N Please describe: _____ _____ _____

Have you ever suffered a stroke, head bleed, concussion or other type of head injury? Y N

If yes, please explain:

_____ _____

**Developmental History:**

Issues during pregnancy Y N Use of drugs/Alcohol/Tobacco during pregnancy Y N

Normal Labor & delivery Y N

If no, please explain:

At what age did you/your child begin: Walking: Talking Toilet training

Developmental delays Y N

If yes, please describe _____

_____

Any significant medical problems during early childhood including hospitalizations Y N

If yes, please describe _____

_____

Are your/your child's immunizations up to date? Y N

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**Social History**

Who are you currently living with? _____

Are your parents currently married? Y N

*****If no and the patient is under the age of 14, BOTH parents must complete the consent for treatment and release of information documents and a legal custody agreement must be provided*****

School name: _____ Grade:

Special Education Y N Repeated any grade Y N

Discipline problems Y N

If yes, please describe:

Involved in Sports Y N If yes, what sports do you play?

Attend Alternative School Program? Y N Name: IEP or

Service Agreement Y N Reasons:

Any school testing done Y N Results:

If applicable: Are you currently working? Y N

Do you spend time with friends after school or on weekends? Y N

Do you enjoy being around friends Y N

Are you bullied at school, on the bus or on social media? Y N

If yes: please describe

Involved in community/social activities? Y N

Please Circle: Church/Temple Clubs Sports AA/NA Volunteer work Other:_____

Hobbies Last enjoyed

---

Do you have a history of past physical/psychological/sexual abuse, neglect, trauma, domestic violence, or have you witnessed domestic violence? Y N

If yes, please describe:

If yes, have you had treatment for the trauma? Y N

If you have not received treatment, would you like to address the trauma during treatment? Y N

Caffeinated Drinks Y N _____cups per day

**Social History**

Current Tobacco Use Y N If yes, do you want to quit? Y N

Type of Usage:

Amount Per Day: How Often? How Long?

Have you ever received treatment? Y N Do you want treatment? Y N

Former Tobacco Use Y N

When Did You Start? When Did You Quit?

Drink Alcohol Y N _____drinks per day/week for _____ years

Have you ever received treatment? Y N Do you want treatment? Y N

Impact social/family life Y N

Have you ever felt that you should cut down on your drinking? Y N

Have people annoyed you by criticizing your drinking? Y N

Have you ever felt bad or guilty about your drinking? Y N

Have you ever had a drink first thing in the AM to steady your nerves? Y N

Do your family/friends complain about your alcohol/drug use? Y N

Current Drug Use/Misuse Y N

IV drug use Y N

Type of Usage:

Amount Per Day: How Often? How Long?

Have you ever received treatment? Y N Do you want treatment? Y N

Former Drug Use/Misuse Y N

Type of Usage:

Amount Per Day: How Often? How Long?

**Current Medications (bring the bottles with you)**

| Name | Dose | How Long | For What | Who Prescribed |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

Do you take any over the counter and/or herbal/natural products? Y N

If yes, please list:

Do you take any medications that belong to a friend/family member? Y N

If yes, please list:

What do you identify as your strengths?

What do you identify as your weaknesses? -

What are your perceived barriers to treatment, if any? -

Any other relevant information _____

_____

I **certify that I have reviewed the above information provided by me, and to the best of my knowledge it is true and complete. I am aware that this information may be released to other parties such as insurance co., attorneys, and other medical professionals/hospitals as per my consent/authorizations, or via court orders as allowed by prevailing federal, state and/or local laws. This information may be shared with treating professionals and/or law enforcement authorities without your consent in case of an emergency, when relied upon in good faith. I will hold Dr. Kant and/or his designees harmless for any loss, injuries, damage that may arise from the actions taken.**

**I/We will be responsible for payment of charges billed if payments are denied by the insurance company/ies for any reason/s. It is my responsibility to update my insurance information for billing whenever there are any changes.**

**Patient Signature**_____
(If the patient is a minor (age 14-18) and received mental health and/or substance abuse treatment, S/he must sign this release)

**Patient Name**_____

**Parent/Guardian/Legal Representative of Patient Signature** _____

**Parent/Guardian/Legal Representative of Patient Name**_____

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

**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

# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us in writing. This authorization will remain in effect until canceled.

| **Credit Card Information** |
|---|
| Card Type: □ MasterCard □ VISA □ Discover □ AMEX<br>□ Other_____ |
| Cardholder Name (as shown on card): _____ |
| Credit Card Number: _____ |
| Expiration Date (mm/yy): _____ |
| Cardholder ZIP Code (from credit card billing address): _____ |
| CVV (3 digits on the back of the card): _____ |

I, _____ authorize NeuroPsychiatry Center to charge my credit card listed above for services provided. This can include self-pay fees, co-payments, deductible, and other charges such as no-show fees, and services not covered under my insurance. I understand my credit card will not be charged more than $300 at one time. I understand that my information will be saved on file for future transactions on my account. I am responsible for keeping this information updated in a timely manner. This authorization will apply to any credit card updates in the future. I am aware that NeuroPsychiatry Center will be unable to notify me before processing this card on file and that my card may be charged at any time at the discretion of NeuroPsychiatry Center for the reasons listed above. These circumstances DO NOT apply to medical assistance recipients.

_____ _____

Patient/Guardian Signature Date