



PATIENT INFORMATION

Where did you find us?

☐ Online Ad ☐ Website ☐ Yelp ☐ Other: _____

Last Name _____

First Name _____ **Middle Name** _____

Date of Birth _____

Gender

☐ Male ☐ Female ☐ Other

SSN: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse Name _____

Home address _____

City _____ **State** _____ **Zip** _____

Email _____

**Your email will be used to invite you to access our Patient Portal.*

Home (_____) _____ - _____

Mobile (_____) _____ - _____

Race

☐ Caucasian ☐ African-American ☐ American Indian/Alaskan Native



☐ Pacific Islander ☐ Asian ☐ Other

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Language ☐ English ☐ Other _____

EMERGENCY CONTACT

Contact Name _____

Relationship _____

Phone Number (_____) _____ - _____

PATIENT STUDENT/ EMPLOYMENT DETAILS

Student Status

☐ Full-Time ☐ Part-Time ☐ Not a Student

School name _____

Employment Status

☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self-Employed ☐ Military Duty

REFERRAL AND PCP

Referring Physician/Therapist _____

OK to disclose information to PCP/ Therapist: _____



LABS AND PHARMACY

Please tell us which lab company you normally use, and your local pharmacy or mail-order pharmacy you use to fill your prescriptions.

Lab:

☐ Quest ☐ LabCorp ☐ Any Test Now ☐ Clinical Pathology Laboratories

Pharmacy:

☐ CVS ☐ H-E-B ☐ Sam's Club ☐ Target ☐ Walgreens ☐ Walmart ☐ Other: _____

Address: _____

Phone Number: (_____) _____ - _____

FINANCIAL RESPONSIBILITY

Primary Insurance Name: _____

Behavioral Phone Number: _____

Member ID Number: _____ Group Number: _____ Insurance

Claim Address (Back of Card): _____

Policy Holder: ☐ Self ☐ Other: _____

Policy Holder DOB: ____/____/____

SSN: _____ - _____ - _____

Secondary Insurance Name: _____

Behavioral Phone Number: _____

Member ID Number: _____ Group Number: _____



INSURANCE ASSIGNMENT AND SELF-PAY AGREEMENT

I certify that I have insurance coverage with the primary insurance company and the secondary insurance payer, if applicable, listed above. I assign directly to Heartland Physicians Associates all insurance payments, if any, otherwise payable to me for services rendered. I understand I am financially responsible for deductibles, co-payments, co-insurance amounts, non-covered charges, and any balances not covered under a signature for all insurance submissions. I request that payment be made of authorized Medicare benefits and, if applicable, Medigap benefits. I understand that it is my responsibility to pay for services rendered at the time of the visit. If insured with an insurance company, please attach the front and back of your insurance card and Texas ID (ID card or Driver's License) with this patient form.

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

Payment for services rendered is the responsibility of the patient, parent, or guardian. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage on your behalf. *However, you are ultimately responsible for the payment of your bill, regardless of insurance coverage.* If additional funds are required after the insurance claim has been processed, any balance will be billed to the patient. If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the patient. If insurance issues arise, it is the responsibility of the patient to contact the insurance company, group plan, administrator, or employer representative for resolution. A patient's insurance policy is a contract between the patient and the insurance carrier. Heartland Physicians Associates and its associates are not parties to that contract and cannot act as a mediator with the carrier or employer. The patient will become responsible for complete payment to the provider if coverage is terminated due to a lack of premium payment.

As required by insurance mandates, it is the responsibility of the patient to obtain any necessary authorization for medical treatments. If a referral is required for treatment, it is the responsibility of the patient to obtain the referral and present it at the time of treatment. If the patient is treated without the proper referral or authorization as required by the insurance carrier, the patient assumes responsibility for payment of all fees at the time of service.

NO SHOW APPOINTMENTS will be charged \$50.00 a NO SHOW FEE. If you need to cancel or reschedule your appointment, please call the office within 24-48 hours of your appointment.

FOR SELF-PAY PATIENTS, new patients will be charged \$300 for the initial appointment and \$180 for appointments thereafter if seen by Dr. Shaikh. If seen by a nurse practitioner, you will be charged \$250 for the initial appointment and \$150 for appointments thereafter.

PATIENT NAME: _____ RELATIONSHIP TO PATIENT: _____

AUTHORIZED SIGNATURE: _____ DATE: _____



CONFIDENTIAL INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I understand that as a client of the providers here at Heartland Physicians Associates, I may be provided with a range of counseling services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks to months.

I understand that all information obtained is confidential, and no information will be shared without my consent. I acknowledge that during the course of my treatment, information may be shared with other healthcare providers in the offices of Heartland Physicians Associates.

I further understand that there are specific and limited expectations of this confidentiality, which include the following:

- When there is a risk of imminent danger to myself or to another person, the clinician is bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child and inform proper authorities.
- When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that while psychotherapy and/or medication may provide significant benefits, they may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories.

Medications may have unwanted side effects. I understand that I need to continue medical care with my primary care physician (PCP) and notify the providers at Heartland Physicians Associates.

I understand that I am required to get these laboratory tests upfront before my new patient appointment: CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), TSH (Thyroid-stimulating hormone), T4 (Thyroxine), liver function tests, and a lipid panel. On a yearly basis, CBC and CMP are required for continuity of care.

PLEASE NOTE: If I cancel my appointment within 24 hours or miss my appointment, I will be charged a \$50.00 fee. If I have more than 3 consecutive cancellations, then I will receive a termination of contract letter. If, at a later time, my circumstances change and I am able to commit to my treatment sessions, then I am welcome back to start my treatment again. Upon termination of treatment, the provider will provide me with a list of providers for continuity of care. At Heartland Physicians Associates, we utilize a comprehensive treatment plan. This means that we may consult your current health care providers in order to provide a thorough treatment plan. At times, it is necessary to make referrals to other providers such as substance abuse treatment, medication evaluation, or testing etc.

If I have any questions regarding this consent form or about the services offered by the providers of Heartland Physicians Associates and its associates, I may discuss them with my providers. I have read and understood the above. I consent to participate in the evaluation and treatment offered to me by Heartland Physicians Associates and its associates, and I understand I can stop treatment at any time.



PATIENT NAME: _____ RELATIONSHIP TO PATIENT: _____

AUTHORIZED SIGNATURE: _____ DATE: _____

CONSENT FOR OFFICE POLICIES AND PATIENT PORTAL POLICIES, AND PROCEDURES

I hereby give consent for Heartland Physicians Associates and their business associates (such as, but not limited to medical billing company, EHR vendor, collection agency, automated appointment reminder vendor, dictation service, and electronic prescription vendor) to use and disclose protected health information about me to carry out treatment, payment, and health care operations. You can ask for a copy of the Notice of Privacy Practices provided by Heartland Physicians Associates, which describes such uses and disclosures in detail.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Heartland Physicians Associates reserves the right to revise its Notice of Privacy practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer at 150 Pine Forest Drive, Suite 804, Shenandoah TX 77384.

With this consent, Heartland Physicians Associates may communicate to me in reference to any items that assist the practice in carrying out TPO, such as, but not limited to appointment reminders, billing statements, insurance issues and any message pertaining to my clinical care including lab results, among others by use of phone calls to my home, mobile or other alternative location and speak or leave a message, text message, email, postal delivery and or by Patient Portal. By signing this form, I am consenting to allow Heartland Physicians Associates to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Heartland Physicians Associates may decline to provide treatment to me. I understand and agree with all the preceding information unless otherwise indicated in writing.

I agree and accept the terms of all these documents.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____



AUTHORIZATION TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I understand that the purpose of this release is to assist with my treatment by improving communication between professional service providers or agencies and the important individual(s) in my life. To further this goal, I, Heartland Physicians Associates, and its associates to release and receive the below-specified information regarding me/the client to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

All patient information is to be disclosed with the exception of items written below; these items will NOT be disclosed. This information is to be disclosed to these persons, who have the indicated relationship to me/the patient:

Name of person: _____ Relationship: _____

Name of person: _____ Relationship: _____

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire upon my discharge from treatment.

Patient Signature: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

Printed name of parent/guardian: _____



HEALTH SCREENING INFORMATION

MEDICAL/SURGICAL HISTORY:

EVENT DATE

CURRENT PSYCHIATRIC MEDICATIONS:

NAME DOSAGE FREQUENCY

ALLERGIES/INTOLERANCES:

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CURRENT STRESSORS AND ADDITIONAL COMMENTS:



FAMILY HISTORY: Has anyone in your family ever been treated for any of the following?

Check all that apply.

	FATHER	MOTHER	AUNT	UNCLE	BROTHER	SISTER	CHILDREN	GRANDCHILDREN
ADHD/ADD								
ALZHEIMER'S								
ANXIETY								
BIPOLAR								
DEPRESSION								
HEART DISEASE								
SCHIZOPHRENIA								
SEIZURES								
STROKE								
SUBSTANCE ABUSE SUICIDE ATTEMPTS								

FOR WOMEN ONLY:

Date of last menstrual period: _____

Are you currently pregnant, or think you may be pregnant? ☐ Yes ☐ No

Are you planning on getting pregnant in the near future? ☐ Yes ☐ No

Birth control method: _____

(Please notify your psychiatrist immediately in case you get pregnant while you are on psychiatric medications.)



CONTROLLED SUBSTANCES ACKNOWLEDGEMENT

Please read carefully and sign for your medical record. A copy will be given to you on

request. I will use my medication(s) exactly as directed by my provider.

I agree not to share, sell or otherwise permit others, including my family and friends, to have access to my medications.

I will not allow or assist in the misuse/diversion of my medication(s); nor will I give or sell them to anyone else. All medication(s) will be obtained at one pharmacy, where possible. Should the need arise to change pharmacies, I will inform my provider. I will use only one pharmacy and I will provide my pharmacist a copy of this form. I authorize my provider to release my medical records to my pharmacist as needed.

I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are specific to my plan of care. If either is lost or stolen, they will NOT BE REPLACED. Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) are allowed when I'm traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out

I will receive medication(s) only from ONE provider unless it is for an emergency or the medication(s) that is being prescribed by another provider is approved by my provider. Information that I have been receiving medication(s) prescribed by other providers that has not been approved by my provider may lead to a discontinuation of medication(s) and treatment.

If it appears to my provider that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my provider may try alternative medication(s) or may taper me off all medication(s). I understand that discontinuation of medications may cause withdrawal symptoms.

I agree to submit to urine and/or blood screens to detect the use of nonprescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., this controlled substance treatment may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified provider such as an addictionologist or a provider who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

I agree that I will inform any provider who may treat me for any other medical problem(s) that I am taking controlled substances, since the addition of other medication(s) may cause harm to me.

I hereby give my provider permission to discuss all diagnostic and treatment details with my other provider(s) and pharmacist(s) regarding my use of medications prescribed by any other provider(s).



I will take the medication(s) as instructed by my provider. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

I will keep all follow-up appointments as recommended by my provider or my treatment may be discontinued.

I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and signing this form while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ9)

Name: _____

Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle the number to indicate your answer)

Not at all (0), Occasionally (1), More than 1/2 the days (2), several days (3)

Trouble falling or staying asleep, or sleeping too much

0 1 2 3

Little interest or pleasure in doing things

0 1 2 3

Feeling bad about yourself or that you are a failure or have let yourself or your family down 0 1 2 3

Feeling down, depressed, or hopeless

0 1 2 3

Feeling tired or having little energy

0 1 2 3



Trouble concentrating on things, such as reading the newspaper or watching television 0 1 2 3

Poor appetite or overeating

0 1 2 3

Moving or speaking so slowly that other people could have noticed or the opposite, being so fidgety or restless that you have been moving around a lot more than usual

0 1 2 3

Thoughts that you would be better off dead, or of hurting yourself in some way

0 1 2 3

TOTAL: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____