Deepti Bhasin, M.D. INC.

Patient Demographic Sheet

Name: _____ DOB: _____ ☐ Male ☐ Female

Social Security Number: ___-___-___ Parent/ Legal Guardian: _____

Is patient adopted, disabled or a foster child? ☐Yes ☐No _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Can we leave messages on your voicemail? ☐Yes ☐No

Preferred method of contact: _____ Email: _____

Would you like to receive e-mails as appointment reminders? ☐Yes ☐No

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____

Primary Care Physician: _____ Referring Physician: _____

Are we able to speak with your Primary Care or Referring Physician about your visits? ☐Yes ☐No

Emergency Contact Name & Relationship: _____ Phone Number: _____

******Please make sure to provide ALL of your CORRECT insurance information below. Failure to do so could result in incorrect billing that could leave you with an unpaid balance that you would be responsible for.***

Primary Insurance Company: _____ ID #: _____ Group #: _____
Insurance Phone Number: _____ Effective Date: _____

Subscriber Name: _____ Relationship: _____

DOB: _____ SS#: ___-___-___

Secondary Insurance Company: _____ ID #: _____ Group #: _____
Insurance Phone Number: _____ Effective Date: _____

Subscriber Name: _____ Relationship: _____

DOB: _____ SS#: ___-___-___

I understand that I am responsible for my deductible, copay or any other balance that my insurance does not cover.

_____ _____

Signature of Patient or Parent/ Legal Guardian Date

PLEASE NOTE: 24- HOUR CANCELLATION POLICY

Showing up as scheduled is one of your most important responsibilities as our patient.

- We **REQUIRE** 24 hours notice in the event of a cancellation. Cancellation notices can always be left on our voicemail system when the office is closed.
- In the event that proper notification **IS NOT** received, this patient is responsible for the payment of $50.00 in full.
- One (1) emergency/ late cancellation without penalty is allowed per calendar year.

I understand that there is a 24-hour ADVANCE notice required to cancel an appointment to avoid being charged the $50.00 fee.

_____ _____

Signature of Patient or Parent/ Legal Guardian Date

MEDICATION REFILL POLICY

Our office policy is that we **DO NOT** do refills. Please be sure you have enough medication to last until your next follow up appointment before leaving the office. Also, make sure that you keep your scheduled appointments to avoid running out of your medications. If it is a controlled substance, then you would have to come in to be seen for a nurse appointment.

I understand that the office does not give refills in between scheduled appointments.

_____ _____

Signature of Patient or Parent/ Legal Guardian Date

TREATMENT WITH PSYCHOACTIVE MEDICATIONS/ PSYCHOTHERAPY

Dr. Bhasin may recommend that you receive psychoactive medications or psychotherapy for the treatment of your diagnosis. There may be side effects or problems that arise from these treatments; I understand that it is my responsibility to inform Dr. Bhasin (or a member of the staff) *IMMEDIATELY* if any of these issues arise during treatment. Some of the medications prescribed to you may not be FDA approved for your diagnosis, or for children, or may be prescribed on a higher dosage than recommended by the FDA.

I hereby consent to treatment with psychoactive medications/ psychotherapy as prescribed by my treating psychiatrist. I understand that I may withdraw this consent at any time & that I have a right to be informed of & consent to any changes in medications/ psychotherapy before they are administered to me.

_____ _____

Signature of Patient or Parent/ Legal Guardian Date

In order to ensure the best & safest possible outcome of your treatment, we need to be aware of **ANY & ALL MEDICATIONS that you are taking, so we will verify your medications with all of your providers.

I understand the necessity of verifying my medications with my other providers & I hereby consent to Dr. Bhasin & office staff to do so.

_____ _____

Signature of Patient or Parent/ Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of Deepti Bhasin, MD INC's Notice of Privacy Practices. This notice describes how they may use and disclose my protected health information, certain restrictions on the use of disclosure of my healthcare information, and rights I may have regarding my protected health information.

****This office is authorized to release any of my information to the following:**

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

*Disclaimer: In your appointment, if a threat or allegation is made to harm yourself or others, in any capacity, Deepti Bhasin, MD INC, will be a mandatory reporter to the appropriate agency.

_____ _____

Signature of Patient or Parent/ Legal Guardian Date

CONSENT FOR TREATMENT

By signing below, you are stating that you have read, understand and accept the office policies and have had the opportunity to have any questions answered. You are authorizing and requesting psychiatric assessment and treatment.

_____ _____

Signature of Patient or Parent/ Legal Guardian **Date**

_____ _____

Printed name of Patient **Printed name of Parent/Legal Guardian**

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

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

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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	