CRESCENT PSYCHIATRY
Sabahat Faheem, M.D.
509 Westpark Way, Suite#110
Euless TX 76040-3991
Phone (817) 571-3800
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GENERAL PATIENT INFORMATION (Please Print)

Patient Name: _____

Date of Birth: _____
Sex: (Circle One) Male/ Female

Occupation: _____

Marital Status: (Circle One) Single / Married / Divorced / Other
Street Address: _____

City/State: _____ Zip: _____

Cell Phone: _____Home Phone: _____

Email Address: _____

Emergency Contact Name: _____

Phone #: _____

Spouse's Name: _____

Cell Phone:_____

Patient's Employer: _____

Employer's Address: _____

Business Phone: _____

INSURANCE INFORMATION (Please Allow Us to Make a Copy of Your Insurance Card and Driver's License)

Primary Insurance: _____

Patient's ID #: _____

Group#: _____

Insurance Company Phone_____

Policy Holder Name: _____

Is there another health insurance benefit plan? _____ Yes_____ No

If yes, please complete information below:

Secondary Insurance:

Insurance Company: _____

ID#: _____ Group#: _____

Insurance Company Phone #: _____

Policy Holder Name: _____

Relationship to Patient: _____ DOB: _____

RESPONSIBLE PARTY INFORMATION (Complete Only if Other Than Patient)

Responsible Party: _____

Home Phone: _____

Cell Phone_____

Relationship to Patient: _____

DOB: _____

Street Address: _____

City/State: _____Zip: _____

Employer: _____

Employer's Address: _____

Employer's phone: _____

If no, please sign statement below: I acknowledge that I do not have a secondary health insurance plan.

_____

Patient's name: _____

Signature: _____Date:_____

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for payment of all co pays, coinsurance amounts, deductibles, and/or noncovered services that are not paid by my insurance company.

Patient's name: _____

Signature: _____Date: _____

Primary care physician: _____

Office Number: _____

Current medications:

_____

_____

_____

_____

ALLERGIES:

1-Name of the medicine_____

Severity: Mild / Moderate / Severe. What was the reaction?

2-Name of the medicine_____

Severity: Mild / Moderate / Severe, what was the reaction?

PHARMACY: _____

Phone: _____

Address: _____

What is the reason for this visit?

_____

_____

_____

_____

CONSENT TO RECEIVE TEXT MESSAGES:

By signing below and providing my wireless phone number to the Crescent Psychiatry staff, I agree and acknowledge that Crescent Psychiatry doctors or staff may send text messages to my wireless phone number.

I agree that these calls may be regarding my appointment reminders or other health related matters.

I acknowledge that this consent may be removed any time at my request. However, until such consent is revoked, I may receive text messages from Crescent Psychiatry at my wireless number.

Patient's name: _____

Signature: _____Date:_____

CONSENT TO PROVIDE MENTAL HEALTH TREATMENT AND CARE:

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to the mental health treatment, as ordered by the psychiatrist, medical care and treatment as provided through Crescent Psychiatry on an outpatient/ office visit. This consent includes all mental health services rendered under the general or specific instructions of the provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Crescent Psychiatry is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments at Crescent Psychiatry Mental Health Clinic.

Telemedicine, I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

Patient's name: _____

Signature: _____Date:_____

CLIENT RIGHTS AND RESPONSIBILITIES

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

This statement is prepared to give you information regarding the client rights and responsibilities. By signing at the bottom of this statement, you are acknowledging that you are aware of your rights and responsibilities as a recipient of services.

The doctor will not publish, communicate, or otherwise disclose information in any records without your signed consent (on a release of information form) except in any case in which there appears to be a clear and imminent danger to yourself or another individual or if such records are required to be released for court proceedings. The doctor is also required by professional ethics and the

Patient's name: _____

Signature: _____Date:_____

laws of the State of Texas to report any potential or actual suspicion of abuse or neglect of a minor child or the elderly.

I authorize Crescent Psychiatry / Sabahat Faheem MD to exchange information regarding my mental health care, substance abuse treatment, or other medical or clinical information. I understand that this consent will remain in effect for one year or throughout my treatment. I may revoke this authorization at any time by written notice to the Crescent Psychiatry.

I have read and understand the information presented to me. I agree to honor the terms of this agreement. I agree to be responsible for the fee incurred or co-payment due at the time of session, and I understand that if my insurance refuses to pay I am responsible for full payment.

Patient's name: _____

Signature: _____Date:_____

NEW PATIENT ACCEPTANCE POLICY: Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Faheem MD. will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient. By signing the bottom of this statement, you are acknowledging that you are aware of office policy for accepting new patients

TERMINATION OF PATIENT CARE POLICY: Crescent Psychiatry reserves the right to terminate the care of an established patient anytime, whenever the doctor decides. The following are the most common termination criterion:

- **Treatment nonadherence**. The patient does not or will not follow the treatment plan.
- **Follow-up nonadherence**. The patient repeatedly cancels follow-up visits or is a no-show.
- **Office policy nonadherence**. The patient uses weekend on-call physicians or multiple healthcare practitioners to obtain refill prescriptions when office policy specifies a certain number of refills between visits.
- **Verbal abuse**. The patient or a family member is rude and uses improper language with the doctor or office personnel,
- **Exhibits violent behavior**, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions.
- **Sexual harassment**. The patient or a family member has exhibited unwelcome verbal or physical behavior of a sexual nature toward office personnel.
- **Nonpayment**. The patient owes the practice and has declined to work with the office to establish a payment plan.
- I have read and understand the information presented to me.

Patient's name: _____

Signature: _____Date: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient: _____

SSN#:_____

I _____authorize Sabahat Faheem M.D./Crescent Psychiatry staff

1- To disclose protected health information to the person/facility
_____

2- Obtain protected health information from the person/facility
_____

Phone: _____

Fax #: _____

The protected health information disclosed is as follows:

MY ENTIRE RECORD ____

ONLY the following information:

____ Psychiatric Evaluation

____ Progress Notes

____ Billing Records

____ Estimated Length of Treatment

____ Other (specify) _____

Initial_____

(Continued to the next page)

The protected health information is being used for the following purposes

(or "at the request of the individual")

____ Medical Care;

____ Case Management (including reimbursement determination and processing of benefit claims.

____ Determination of employment status (including disability leave);

____ Other (specify)_____

The information may include information on HIV, AIDS, alcohol use, drugs and mental health.

This authorization shall be in force and effect until I revoke this authorization to use or disclose the protected health information.

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the Crescent Psychiatry. A revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and my insurer has legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient's name:_____

Patient signature: _____Date:_____

PATIENT TREATMENT CONTRACT

As a participant in treatment, I freely and voluntarily agree to accept this treatment contract
as follows:

1. I consent to treatment by my providers.
2. I agree to keep and be on time to all my scheduled appointments to the best of my ability.
3. I agree to adhere to the financial policy outlined by this office.
4. I agree to conduct myself in a courteous manner in the doctor's office.
5. I agree not to sell, deal, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement
and would result in my treatment being terminated.
6. I agree not to steal, or conduct any illegal or disruptive activities in office.
7. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the
behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
8. I agree that my medication/prescription can only be given to me at my regular office
visits. A missed visit may result in my not being able to get my medication/prescription until
the next scheduled visit.

Patient's name:_____

Patient signature_____Date:_____

(Continued to next page)

9. I agree that the medication I receive is my responsibility and I agree to keep it in a safe,
secure place. I agree that lost medication will not be replaced regardless of why it was lost.
10. I agree not to obtain medications from any doctors, pharmacies, or other sources without
telling my treating physician.

11. I understand that as part of my treatment plan it is required that I see the physician on a
regular basis as part of my treatment and no prescriptions will be written without an office
visit. Subsequently I understand that if I do not keep appointments regular with my provider
and a period of 60 days elapses, I may be discharged as a patient from care.
12. I agree to take my medication as my doctor has instructed and not to alter the way I take
my medication without first consulting my doctor.
13. I agree to come in and appear upon 48 hours' notice for a pill count where I will bring in
my prescribed medication for inspection at the notice of CBHS representative.
14. I understand that I may be screened for drug abuse or use at any time.

Patient's name:_____

Patient signature_____Date:_____

NO SHOW / CANCELLATION POLICY:

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment.

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations.

Crescent Psychiatry's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 48 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

The doctor has a limited number of hours available each week. When a client cancels an appointment without sufficient notice, this not only prevents you from your scheduled appointment but may also disallow other clients utilizing this time. Thus, if you must cancel an appointment, you will be charged a fee ($50) if a 48-hour notice is not given. After three un kept appointments in a row we will assume that you no longer desire the doctor's services and your treatment will be terminated.

Patient's name:________

Patient signature_____Date:_____