REHAN PURI
HEALTHY MIND WORLD LLC

Rehan Puri, MD
825 Market Street Blvd, Suite 250, Allen, TX, 75013

Welcome to Healthy Mind World LLC. We are delighted and honored you have chosen us for your Mental Health Urgent Care services.

Attached is our patient registration forms and contract. Kindly complete these forms before your visit. Please bring the completed forms, your insurance card, government issued identification, and your payment to your first visit. You will receive a copy of the contract and all receipts.

We do not offer emergency services. If you should have an emergency before your first appointment or between appointments, please go to the nearest emergency room or call 911 for all emergencies. If you have any questions or concerns please feel free to ask.

Again, Welcome!

Sincerely,

Office Manager

Rehan Puri, MD
825 Market Street Blvd, Suite 250, Allen, TX, 75013

Patient Information

Patient Name: _____
DOB: (mm/dd/yy): _____ SSN: _____
Email: _____ Gender: M F
Mailing Address: _____
City: _____ ST: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Employer Name: _____ Position: _____
Emergency Contact: _____ Relationship: _____

IF CHILD, PARENT INFORMATION
Mother's Name: _____ Living with Child? YES NO___
DOB (mm/dd/yy): _____ Daytime Phone #: _____
Father's Name: _____ Living with Child? YES NO
DOB (mm/dd/yy): _____ Daytime Phone #: _____

If Applicable, Circle One: Child is .....

Adopted Under Guardian Care Under Foster Care

If so, Give Name (s) of Parent(s):
_____

Financial Party Information

Name: _____Phone: _____
Mailing Address: _____
Relationship to Patient: _____

Reason for My Visit Today

Please tell us why you're come to see us today:
_____

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Consent to Obtain Prescription History

This consent form authorizes Healthy Mind World LLC to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names and dosages.

Understanding the above, I hereby provider informed consent to Healthy Mind World LLC to request, view, and use my external prescription history for treatment purposes.

Patient Name (Printed): _____DOB: _____

Patient/Guardian Signature: _____ Date_____

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Contract and Consent for Evaluation/Treatment

I, _____, ("Client/Guardian") request treatment for myself at Healthy Mind World LLC. may include diagnosis, evaluation, and treatment for any medical, emotional and behavioral problem, which may be found to exist.

Liability
In consideration of services rendered, Client agrees to hold Healthy Mind World LLC. blameless for any liability due to an accident, illness, injury, or incident, which may occur to Client while receiving outpatient services. Client also agrees to hold Healthy Mind World LLC. free from all liability for any losses through fire or theft. Client agrees, if hospitalization or extensive medical Healthy Mind World LLC. to assist the client in obtaining appropriate medical attention. Further, the family, guardian, or Client is needed, that permission is hereby given to any agent of will assume all liability for any medical expenses, hospital care, or other expenditures without liability to Healthy Mind World LLC.

Records
Requests for records are received from various sources. Attention to these requests will only occur when we have received a signed (by patient or parent) release of information form. Records are copied at $30.00 plus postage and billed directly to you. Please allow two weeks for this request to be processed.

Prescriptions
To prevent error and to maintain insurance and healthcare standards most prescriptions cannot be called in to the pharmacy. A charge of $10.00 for prescriptions that are misplaced lost or not filled in the 21 day time frame for controlled substances. You must return the expired prescription and pay the fee by check or cash.

Confidentiality
I have further been assured that any information, knowledge, or records associated with said Client are subject to release only by my informed and written consent or by a court order, except in instances of medical emergency or suspected child or elder abuse or neglect. Your confidentiality and privacy are protected by the following Federal guidelines: Code of Federal Regulations (CFR 42 Part2) and the Health Insurance Portability and Accountability Act (HIPAA).

Discrimination Policy
No person will be discriminated against on the basis of gender, race, religion, age, national origin, disability (mental of physical), sexual orientation, medical condition, including HIV diagnosis or because an individual is perceived as being HIV infected. A person's economic condition and financial resources may be considered in admission
criteria, but economic condition will not affect the services once an individual is admitted.
By signing this document, Client acknowledges that she/he understands the policy contained herein, and that if at any time there are questions, Client may return to a Healthy Mind World LLC. staff member for an explanation. _____ **(*please initial*)**. Consent for treatment is made with informed consent, and as such, consent may be revoked and services discontinued at any time. By signing below, Client acknowledges she/he has read the above information and fully understands
its contents.

Patient/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

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Financial and Office Policies

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. The following are our Financial and Office Policies. Please **read, initial, on the left, sign** at the bottom and return to the front office representative. Please ask us any questions that you may have.

_____ Since Healthy Mind World LLC. is not a full-service clinic, we are unable to provide certain services. We do not prescribe any DEA controlled substances (Xanax, Adderall, Lorazepam, etc.) nor do we prescribe refills. We ask that all our patients make follow-up appointments to maintain their medications.

_____ Healthy Mind World LLC. serves as a short-term care clinic. When you come into our clinic, you will be provided with an assessment by a licensed clinical social worker or licensed professional counselor. You will receive access to services provided by a psychiatrist or psychiatric nurse practitioner. These services will assist in gaining any immediate understanding of your needs, provide you with a safety plan, coping skills, and medication services if indicated. We will also assist you in developing a longer term mental health plans if needed.

_____ Documentation: We will not do any FMLA or disability paperwork.

_____ **Patient Responsibility**: We DO NOT participate on any insurance plans. We are self-pay facility and we do not bill your insurance company. You are required to pay in full at the time of service. We can provide you with insurance paperwork for individual reimbursement.

_____ **Fee Schedules**: I understand and agreed with the clinic's fee schedules.

Initial Crisis Assessment: $300.00

Follow-up Consultations/Short term counseling Services: $110.00

Individual Therapy: $110.00

Group Therapy: $75

Patient Name: _____

Patient Signature: _____

Date: _____

If minor, Guardian's Name: _____

Guardian's Signature: _____

CLIENT BILL OF RIGHTS

As a client receiving services from Healthy Mind World LLC., your Client Bill of Rights will include the following:

1. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
2. You have the right to be free from abuse, neglect, and exploitation.
3. You have the right to be treated with dignity and respect.
4. You have the right to appropriate services in the least restrictive setting available that meets your needs.
5. You have the right to be told about the program's rules and regulations before you are admitted.
6. You have the right to be told before admission:
   - the condition to be treated
   - the proposed treatment
   - the risks, benefits, and side effects of all proposed treatment and medication
   - the probable health and mental health consequences of refusing treatment
   - other available treatments and which ones, if any, might be appropriate for you
   - the expected length of treatment
7. You have the right to accept or refuse treatment after receiving this explanation.
8. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).
9. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
10. You have the right to meet with staff to review and update the plan on a regular basis.
11. You have the right to refuse to take part in research without affecting your regular care.
12. You have the right not to receive unnecessary or excessive medication.
13. You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
14. You have the right to be told in advance of all estimated charges and any limitations on the length of services that the facility is aware of.
15. You have the right to receive an explanation of your treatment or your rights if you have questions while you are receiving services.
16. You have the right to make a complaint and receive a fair response from the staff within a reasonable amount of time.
17. You have a right to complain directly to the Texas Commission on Alcohol and Drug Abuse at any reasonable time.

Department of Investigations

Texas Department of State Health Services

P.O. Box 149347Austin, Texas 78714

1-800-832-9623

18. You have a right to get a copy of these rights before you receive services, including the Commission's address and phone number.
19. You have the right to have your rights explained to you in simple terms before receiving services.

I (we) have received from Healthy Mind World LLC. staff a clear explanation of my (our) rights in simplest terms. I (we) have received a written copy of these rights. I (we) acknowledge a clear understanding of my (our) rights.

_____ _____

Patient/Guardian Signature Date

_____ _____

Staff Signature Date

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Client History

Personal Medical/Surgical History

Do you have any medical conditions? YES NO
If yes, please list and explain?

_____

_____

Current Medications

Are you taking any medications? YES NO
If yes, please list them

_____

_____

Please check any psychoactive medication you or your child has taken in the past. Please indicate if they were helpful or not, and why you were stopped. Put an "H" if they were helpful and "NH" if they were not helpful.

Mood Stabilizers:
___ Geodon
___ Abilify
___ Depakote
___ Risperdal
___ Seroquel
___ Lithium
___ Tegretol
___ Haldol
___ Other:
_____

Stimulants:
___ Ritalin
___ Adderall
___ Concerta
___ Vyvanse
___ Straterra
___ Other:
_____

Antidepressants:

___ Trazadone
___ Zoloft
___ Prozac
___ Cymbalta
___ Celexa
___ Lexapro
___ Other: _____

Comments (or side effects:): Notes dates and dosage if known:
_____
_____
_____
_____

Drug Allergies

Please list all know allergies

_____

_____

Family Psychiatric History

Father:_____

Mother:_____

Siblings:_____

Your Past Psychiatric History

Do you have any past psychiatric history? YES NO
If yes, please list them

_____

_____

_____

Past Mental Health History - Please list any previous psychiatrist, psychologist or therapist you have seen:

Name of Person Seen	Dates seen (mo/yr-mo/yr)	Medications Prescribed	Reason Hospitalized? (yes/no-where)
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Social History

- Marital History: _____
- Siblings: _____
- Living Situation: _____

Abuse

- Physical: _____
- Emotional: _____
- Sexual: _____

- Alcohol: _____
- Tobacco: _____
- Drug Use: _____

Presenting Information

What are the main problem(s) that brought you to the doctor?

_____

_____

When did the problem(s) first begin?

_____

_____

Current Symptoms

Please explain your current symptoms.

_____

_____

Review of Symptoms

Headaches	Present	Non-Present
Dizziness/Vertigo	Present	Non-Present
Convulsions or Seizures	Present	Non-Present
Vision Problems	Present	Non-Present
Hearing Problems	Present	Non-Present
Smelling or Taste Problems	Present	Non-Present
Thyroid Problems	Present	Non-Present
Cough/Asthma	Present	Non-Present
Chest Pain	Present	Non-Present
Nausea/Vomiting	Present	Non-Present
Abdominal Pain	Present	Non-Present
Constipation	Present	Non-Present
Urinary Problems	Present	Non-Present
Arthritis	Present	Non-Present
Walking Problems	Present	Non-Present

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Adult Rating Scale

Patient Name: _____ Date: _____

Please answer questions 1-18 using:
A=most of the time
B=Often
C=Occasionally
D=Rarely
E=Never

Patient Question	Patient Response	Interview Comments
	INATTENTION	
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?		
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?		
3. How often do you have problems remembering appointments or obligations?		
4. When you have a task that requires a lot of thought how often do you avoid or delay getting started?		
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?		
6. How often do you feel overly active and compelled to do things like you were driven by a motor?		
7. How often do you make careless mistakes when you have to work on a boring or difficult project?		
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?		
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?		
	HYPERACTIVITY	
10. How often do you misplace or have difficulty finding things at home or at work?		
11. How often are you distracted by activity or noise around you?		
12. How often do you have to leave your seat in meetings or other situations in which you are expected to remain seated?		
13. How often do you feel restless or fidgety?		
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?		
15. How often do you find yourself talking too much when you are in social situations?		
	IMPULSIVITY	
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?		
17. How often do you have difficulty waiting your turn in situations when turn taking is required?		
18. How often do you interrupt others when they are busy?		
RATING CALCULATION		
ASRS RESULT		

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Children Rating Scale

Patient Name: _____ Date: _____

Please answer questions 1-18 using:	Answer question 19:	Answer Question 20:
A= Most of the time B= Often C= Occasionally D=Rarely E=Never	YES or NO	Home School Work

Patient Question	Patient Response	Interview Comments
	INATTENTION	
1. Does your child fail to pay close attention to details or makes careless mistakes in schoolwork, work, or other activities?		
2. Does your child have trouble keeping attention on tasks or play activities?		
3. Does your child not seem to listen when spoken to directly?		
4. Does your child not follow instructions and fails to finish schoolwork, chores, or duties in the workforce?		
5. Does your child have trouble organizing activities?		
6. Does your child avoid, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time?		
7. Does your child lose things needed for tasks and activities?		
8. Is your child easily distracted?		
9. Is your child forgetful in daily activities?		
	HYPERACTIVITY	
10. Does your child fidget with hands or feet or squirms in seat?		
11. Does your child get up from seat when remaining in seat is expected?		
12. Does your child run about or climbs when and where it is not appropriate?		
13. Does your child have trouble playing or enjoying leisure activities quietly?		
14. Is your child "on the go" or often acts as if "driven by a motor"?		
15. Does your child talk excessively?		
	IMPULSIVITY	
16. Does your child blurt out answers before questions have been finished?		
17. Does your child have trouble waiting one's turn?		
18. Does your child interrupt or intrude on others?		
	DURATION FACTORS	
19. Have symptoms been present for at least six months?		
20. Which of the following locations are these symptoms present as well? (Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder)		
RESPONSES SUGGEST ADHD TYPE		