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 psychiatric 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,

Rehan Puri, MD

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Patient Information

Patient Name: _____ Gender: M F
DOB: (mm/dd/yy): _____ SSN: _____ Email: _____
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 #: _____
Employer Name: _____ Position: _____
Father's Name: _____ Living with Child? YES NO_____
DOB (mm/dd/yy): _____ Daytime Phone #: _____
Employer Name: _____ Position: _____

If Applicable, Circle One: Child is ..... Adopted Under Guardian Care Under Foster Care
If so, Give Name (s) of Parent(s): _____

PRIMARY CARE PHYSICIAN

Doctor's Name: _____ Phone #: _____
Mailing Address: _____City:_____ ST: _____Zip Code:_____

REFERRAL SOURCE

Title and Name: _____ Phone #: _____
Mailing Address: _____ City: _____ ST: _____Zip Code:_____

PRIMARY INSURANCE

Insurance Name: _____Phone: _____
Mailing Address: _____
Policy Number: _____ Group #: _____ SSN: _____
Name of Insured: _____ DOB: _____
Employer Name: _____ Relationship to Patient: _____

SECONDARY INSURANCE

Insurance Name: _____Phone: _____
Mailing Address: _____
Policy Number: _____ Group #: _____ SSN: _____
Name of Insured: _____ DOB: _____
Employer Name: _____ Relationship to Patient: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Healthy Mind World, LLC to release my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Healthy Mind World, LLC. I understand that I am ultimately responsible for all services weather covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

Contact 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 care 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

Financial Responsibility
Client and/or financially responsible party have been informed that she/he is financially responsible for services received at Healthy Mind World, LLC, unless payment is otherwise assured. The Client and/or financially responsible party have been further informed of all applicable co-pay fees. If, for any reason, your insurance company fails to pay any portion of the amounts we billed, you will be responsible for the balance and will be billed accordingly. All co-pays and deductible are due at the time of service. We charged $200-$350 for the initial doctor's appointment. Continue therapy , including medication management follow-ups, will be a charge of $80-$175.00. It is agreed that Client will provide Healthy Mind World, LLC with a permanent contact address and telephone number.

Returned checks are assessed a $30.00 fee. You agree to pay your bill within 10 days of receipt. If payment is not received within 90 days, your account will be turned over to collections. We have the option to pursue all lawful collection procedures available and the patient/parent will be responsible for all the reasonable costs of collection, including attorney's fees incurred, if any. The minimum collection fee will be 50% of the total account balance. Unwillingness to pay may result in termination of services.

Cancellations
We see all patients on an appointment basis. If you are unable to keep your scheduled appointment, please cancel as soon as possible so your allotted time may be given to another patient. We reserve the right to charge for missed appointments no called within 24 hours. The charge is $50.00 billed to you, not the insurance. Continued missed appointments may cause patient termination.

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 $25 plus postage and billed directly to you. Please allow two weeks for this request to be processed.

Letters
Letters and forms are often requested by patients (or their parents) to be sent to schools, employers, etc. You will be charged a letter writing fee for this service, minimum of $25.00. We do not complete forms for Disability.

Telephone Calls
Your calls are welcome and we will return them promptly during business hours. We do not have after hour's answering service. You must call the office and leave a voicemail message. If you need to make an appointment please call during our business hours. If you have an emergency, please call 911 or go to the nearest emergency room.

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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.

Notice Regarding RX Refills

We require 7 BUSINESS DAYS NOTICE for prescription refills to be sent to ReCept Pharmacy or to be picked up in the office. Please have your pharmacy fax all other refill requests to our office at 972-724-2111. Please allow 48 hrs for refill requests to be faxed back to the pharmacy.

Beginning January 1, 2010, we will no longer authorize refills faxed to us from the Pharmacy when the patient has been given a prescription in the office.

Termination
Clinic policy states that the third appointment that is not kept and/or follow up with in four months will be regarded as termination of treatment on the part of the patient/client, unless we as a team have decided otherwise. If you fail to comply with treatment recommendations termination is non-negationable.

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 Signature Date

_____/_____ _____
Financially Responsible Party Signature/Relationship to Patient Date

_____ _____
Staff Signature Date

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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
    Substance Abuse Services
    P.O. Box 149347
    Austin, 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:
_____
_____
_____
_____

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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-Presen

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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		