Enhance Psych, Inc.

Raj Loungani, MD, MPH

PATIENT INFORMATION FORM

□ New patient □ Address Change □ Name Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date: ____/____/____

Patient Name: ____

Last *First* *M.I*

Date of Birth:____/____/____ Age: ______ Sex: ☐ Male ☐ Female

Social Security Number: ____-____-____

Address:____

Street *City* *State* *Zip*

Home Phone: ( )____________________ Work Phone: ( )____________________

Cell Phone: ( )_____________________ Email:__________________________________

How would you prefer that we contact you about your care? (Please indicate Y/N for Yes or No) ___ Home ___Work ___Cell ___Email

Permission to leave a voicemail? (Please indicate Y for N) ___ Home ___Work ___Cell

Pharmacy: ____

Name *Street* *City* *State* *Zip*

Pharmacy Phone: ( )____________________

<u>IF PATIENT IS A MINOR:</u>

Parent/Legal Guardian Name:____

Last *First* *M.I*

Address:____

Street *City* *State* *Zip*

Home Phone: ( )___________________ Work Phone: ( )___________________

Cell Phone: ( )____________________ Email:_________________________________

How would you prefer that we contact you about the Patient's care? (Please indicate Y or N) ___ Home ___Work ___Cell ___Email

Permission to leave a voicemail? (Please indicate Y for N) ___ Home ___Work ___Cell

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EMERGENCY CONTACT INFORMATION
(To be completed for all patients)

Name:____

Last *First* *M.I*

Relationship to Patient: ____

Home Phone: ( )____________________

Work Phone: ( )____________________

Cell Phone: ( )____________________

TREATMENT PROGRESSION CONTACT INFORMATION

I authorize Dr. Loungani to speak with the following individuals regarding the progression of my treatment. I understand that Dr. Loungani may contact these individuals by phone to ask questions about my behavior in order to better determine how my treatment is progressing. **I understand that I do not have to complete this form in order to receive treatment.**

1. ____ ____
Name Phone Number

____
Relationship

2. ____ ____
Name Phone Number

____
Relationship

3. ____ ____
Name Phone Number

____
Relationship

EXPIRATION DATE: This authorization will expire three (3) years from the date listed at the top of this form unless a different expiration date or expiration event is written here: ____.

REVOCATION: I understand that I have the right to revoke this authorization in writing any time, however I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the Practice shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare when the law provides my insurer with the right to contest a claim under my policy. Written notice should be directed to Raj Loungani, MD, MPH, the company's Privacy Officer.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

Patient or Parent/Legal Guardian Name____

Signature_____________________________________ Date ____/____/____

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NEW PATIENT MEDICAL HISTORY

PSYCHIATRIC HISTORY

What is the reason for your visit with me today? ______________________________

____

____

What do you hope to get out of your visit(s) with me? ______________________________

____

____

How did you hear about me? ______________________________

____

Have you ever been treated for or diagnosed with any psychiatric disorders? Y N

If yes, please explain (including diagnosis/problem, dates of treatment/diagnosis, suggested treatment, whether you followed treatment recommendation, whether treatment recommendation helped, etc.): ______________

____

____

Have you ever sought treatment with a psychiatrist or any other mental health treatment? Y N

If yes, please explain (including reason for seeking treatment, dates, outcome of treatment, etc.): ______________

____

____

FAMILY PSYCHIATRIC HISTORY:

Please list any family history of psychiatric problems, including, but not limited to depression, bipolar illness, alcoholism, drug addiction, anxiety, phobias, and eating disorders, among others.

Name	Relationship to You	Psychiatric Diagnosis or Problem
______________	______________	______________________
______________	______________	______________________
______________	______________	______________________
______________	______________	______________________

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NEW PATIENT MEDICAL HISTORY

GENERAL MEDICAL HISTORY: *Place an **X** next to any illness or condition that you have had or have now.*

Condition		Condition	
Angina	________	Hepatitis	________
AIDS	________	Herpes	________
Anemia	________	Hiatal Hernia	________
Arthritis	________	High Blood Pressure	________
Asthma	________	High Cholesterol	________
Bloody or Tarry Stools	________	HIV	________
Bone Fracture	________	Irritable Bowel Syndrome	________
Bronchitis	________	Jaundice	________
Cancer	________	Kidney Disease	________
Chronic Back Pain	________	Kidney Stones	________
Chronic Constipation	________	Mitral Valve Prolapse	________
Chronic Diarrhea	________	Narcolepsy	________
Colitis	________	Osteoporosis	________
Congestive Heart Failure	________	Pancreatitis	________
Coronary Disease	________	Peptic Ulcer	________
Crohn's Disease	________	Plastic Surgery	________
Diabetes	________	Pneumonia	________
Diverticulitis	________	Prostate Problems	________
Dizzy Spells	________	Psoriasis	________
Eczema	________	Recurrent Nose Bleeds	________
Emphysema	________	Seizures	________
Fainting Spells	________	Shingles	________
Fibromyalgia	________	Sinus Problems	________
Gall Bladder Disease	________	Sleep Apnea	________
Glaucoma	________	Stress Urinary Incontinence	________
Gout	________	Stroke	________
Hay Fever	________	Thyroid Disease	________
Headaches	________	Tremor	________
Hearing Problems	________	Tuberculosis	________
Heartburn	________	Vision Problems	________
Heart Attack	________		

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NEW PATIENT MEDICAL HISTORY

Have you ever had or currently have any other illness or condition (circle one)? Y N

If yes, please explain:____

____

Have you ever had any surgical procedures or been hospitalized for any other reason (circle one)? Y N

If yes, please explain (including dates):____

____

____

Have you ever been knocked out after being hit on the head (circle one)? Y N

If yes, please explain:____

____

____

Please list all current medications, including vitamins, supplements and other herbal preparations: ___________

____

____

Please list all allergies to medications: ____

____

____

Height: _______ inches *Weight: _______ pounds*

FOR FEMALE PATIENTS ONLY:

Age of First Menstrual Period ____________________

First Day of Last Menstrual Period ____________________

Are your periods regular? ____________________

How many times have you been pregnant? ____________________

How many children were born alive? ____________________

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NEW PATIENT SOCIAL HISTORY

Please answer the following questions so that I can get to know you better!

1. *Where were you born?*

____

____

2. *Where did you grow up?*

____

____

3. *What is the highest level of education you achieved? What schools have you attended?*

____

____

4. *Are you employed outside of the home? If so, where? What is your job title?*

____

____

5. *What is your religion, if any? Are you religious?*

____

____

6. *With whom do you live? Where (single family home, apartment, condominium, etc.)?*

____

____

7. *What are your hobbies? What do you like to do for fun?*

____

____

8. *Whom do you turn for when you need emotional support?*

____

____

9. *What are some of your strengths, talents, and other positive attributes?*

____

____

10. *Have you ever had any legal problems, either criminal or civil?*

____

____

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NEW PATIENT SOCIAL HISTORY

11. *Have you ever been in the military? If so, when and what branch?*

____

____

12. *Do you currently:*

Consume Caffeine Y N

If yes, how much per day? __________

Drink Alcohol Y N

If yes, how many drinks per day? __________

Smoke Cigarettes or Vape Y N

If yes, how many packs per day? __________

If no, have you ever smoked, and when did you quit? __________

Smoke/Consume Marijuana/Cannabis Y N

If yes, how many times or how much quantity per day? __________

If no, have you ever smoked/consumed marijuana/cannabis, and when did you quit? __________

Exercise Y N

If yes, how many times per week? __________

Eat a specific type of diet Y N

If yes, what type of diet? __________

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CONSENT FOR PSYCHIATRIC TREATMENT

1. Consent to Evaluate/Treat: I voluntarily consent to participate in a mental health (or psychiatric) evaluation and/or treatment. I acknowledge that following the evaluation and/or treatment, information will be provided to concerning each of the following areas:

    a. The benefits of the proposed treatment;
    b. Alternative treatment modes and services;
    c. The manner in which treatment will be administered;
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable); and
    e. Probable consequences of not receiving treatment.

    I understand that the evaluation or treatment will be conducted by a psychiatrist. Treatment will be conducted within the boundaries of Florida law.

2. Risks, Benefits, and Alternatives to Evaluation/Treatment: I understand that Dr. Loungani may evaluate and treat me through a variety of methods, such as psychological/psychiatric interviews, psychological/psychiatric assessments or testing, psychotherapy, medication management, and that these methods may vary in length and frequency. I also it will be beneficial to Dr. Loungani, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning so that he can offer appropriate recommendations and treatments. Uses of Dr. Loungani's evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning.

    I understand that possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations. Possible risks include bad interactions with prescribed medications, which could cause discomfort, injury or death. Alternatives to psychiatric treatment include mental health counseling, treatment by a general medical doctor, and self-help, such as through education or lifestyle changes.

3. Confidentiality, Harm, and Inquiry: Information from Dr. Loungani's evaluation and/or treatment is contained in a confidential medical record. I hereby consent to disclosure for use by Enhance Psych and Dr. Loungani's staff for the purpose of continuity of my care. I acknowledge that pursuant to Florida mental health law, information provided will be kept confidential with the following exceptions:

    a. If I am deemed to present a danger to myself or others;
    b. If concerns about possible abuse or neglect arise; or
    c. If a court order is issued to obtain records.

4. Right to Withdraw Consent: I understand that I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to Dr. Loungani.

Enhance Psych, Inc.

Raj Loungani, MD, MPH

CONSENT FOR PSYCHIATRIC TREATMENT

I have read and understand the above informed consent, have had an opportunity to ask questions about this information. I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment and I have not been deemed incapable of giving such consent by any court. I understand that I have the right to ask questions of Dr. Loungani about the above information at any time. I acknowledge I received the patient's bill of rights.

Patient or Parent/Legal Guardian Name____

Signature_____________________________________ Date ____/____/____

Enhance Psych, Inc.

Raj Loungani, MD, MPH

PATIENT INFORMED CONSENT FOR TELEMEDICINE
(for mental health – psychiatry and psychotherapy)

This Informed Consent contains important information about you receiving psychiatry and psychotherapy via telemedicine, meaning over the phone or the internet. Please read this carefully, and let me know if you have any questions. I will answer them for you. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychiatry and psychotherapy services remotely (you're your physician or other provider in one location and you in the other) using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that you and your provider can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the patient takes an extended vacation, cannot leave the home, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful and safe. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy, as required by HIPAA and Florida law. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we may develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non- verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

Confidentiality

Providers have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that they cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in the general Consent for Psychiatric Treatment that you signed still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (904-834-9100).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session (i.e. you will be unable to reimburse these sessions with your insurer). Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent ("Consent for Psychiatric Treatment") that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

Patient or Parent/Legal Guardian Name____

Signature_____________________________________ Date ____/____/____

Enhance Psych, Inc.

Raj Loungani, MD, MPH

PATIENT FINANCIAL POLICY

PAYMENT METHODS. I understand that Dr. Loungani does not accept insurance, Medicare, or Medicaid and that I am fully responsible for all financial obligations related to my evaluation and treatment with Dr. Loungani. I understand that Dr. Loungani accepts the following forms of payment: Credit card (Visa, MasterCard, Discover, AMEX), debit card, HSA/FSA card, check or cash. I also understand that I am required to keep a credit card on file with Dr. Loungani, and authorize Dr. Loungani to automatically bill my credit card if I do not make payment at the time the service is provided, or if I otherwise incur any charges in accordance with this Patient Financial Policy.

INSURANCE CLAIMS. I understand that I am responsible for submitting out-of-network claims for insurance reimbursement. I authorize Dr. Loungani and his staff to release any information necessary for such claims processing. I understand that there is no guarantee of payment by any insurance company or third party payer and I am ultimately responsible for payment in full at the time of service.

INITIAL VISIT FEE. I understand that Dr. Loungani charges $549.99 for an initial visit.

FOLLOW-UP VISITS AND FEES FOR EXTENSIVE COMMUNICATION. I understand that Dr. Loungani charges for follow-up visits and extensive communication (including extensive texts, calls, or emails returned by Dr. Loungani) based upon the length of the visit/communication and the complexity of the matter involved, which corresponds to various medical billing codes. I understand that Dr. Loungani charges for prescriptions between visits and for Prior Authorizations and other forms or letters, based on the length of time required to complete them.

I understand that there is no financial charge for phone calls to Dr. Loungani or his staff regarding appointment scheduling, billing, and other routine administrative matters.

NO-SHOW/LATE CANCELLATION FEE. You will be responsible for paying a no-show fee of the cost of the missed appointment ($249.99 for 25 min. med management visit, $349.99 for 50 min. psychotherapy +/- med management visit, $449.99 for 75 min. psychotherapy +/- med management visit) for missed appointments or appointments not cancelled at least 48 hours in advance of the scheduled appointment.

RETURNED CHECK FEE. You will be subject to an additional fee for returned checks, which will be determined by the depository bank.

DELINQUENT ACCOUNTS. Should your account be placed with a collection agency due to delinquent status, the administrative cost of such action, along with any attorneys' fees and court costs, will be added to the balance of the account at the time of placement with the collection agency.

BILLING. I understand that Dr. Loungani does not accept insurance, Medicare or Medicaid, and that I am fully responsible for all financial obligations incurred. I understand that payment is due in full at the time of service.

Patient or Parent/Legal Guardian Name____

Signature____________________________________ Date ____/____/____

Enhance Psych, Inc.

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CREDIT CARD AUTHORIZATION

In accordance with the Patient Financial Policy, I understand that all payments are due at the time of service. Any charges not paid in full at the time of service, as well as any other fees charged in accordance with the Patient Financial Policy, will be automatically charged to my credit card.

Name on Credit Card: ____

Billing Address: ____

____

Card Number: ____

Expiration Date: __________________________________

3-Digit CVS Code (on back of card), for AMEX 4-Digit Code (on front of card): ___________________

Type of Card (please circle one): Visa MasterCard Discover AMEX

I hereby authorize Enhance Psych, Inc. and Raj Loungani, MD, MPH, to maintain my credit card information on file and to charge my credit card for any services rendered if payment is not otherwise made at the time of my appointment or IF other payment arrangements are not approved by Dr. Loungani. I also authorize the charge on my credit card for any fees incurred in accordance with the Patient Financial Policy, including, but not limited to, late cancellation fees and returned check fees. I understand that any charges to my credit card will appear on my credit card statement as being billed by "Enhance Psych."

Patient or Parent/Legal Guardian Name____

Signature____________________________________ Date ____/____/____