REHAN PURI
HEALTHY MIND WORLD LLC

Rehan Puri, MD

PATIENT REGISTRATION

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle Initial) Preferred Name

Mailing Address: _____

Phone: (H) _____ (C) _____ (W) _____

Social Security #: _____ Sex: □ Male □ Female DOB: _____ Age: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Other _____

MAY WE CONTACT YOU BY PHONE FOR APPOINTMENT REMINDERS: □ YES □ NO IF YES PREFERRED # □ H □ C □ W

Email Address: _____

RESPONSIBLE PARTY INFORMATION (Person who is financially responsible for payment)

Name: _____ DOB: _____

Relationship to Patient: _____ SS #: _____

Mailing Address: _____

Phone: (H) _____ (C) _____ (W) _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Phone #: _____

Name of Insured: _____ Relationship to Pt.: _____

Insured SS#: _____ Insured DOB: _____

Insured Mailing Address: _____

Effective Date: _____ Employer: _____

Policy #/ Member ID: _____ Group ID# _____

Secondary Insurance Company: _____ Phone #: _____

Insurance Address: _____

Name of Insured: _____ Relationship to Pt.: _____

Insured SS#: _____ Insured DOB: _____

Insured Mailing Address: _____

Effective Date: _____ Employer: _____

Policy #/ Member ID: _____ Group ID# _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____ Phone : _____

PATIENT SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENTS AND CONSENT

_____ I voluntarily consent to receive treatment at Allen Psychiatry. I consent to administration and performance of treatment/diagnostic procedures/ laboratory tests as deemed medically necessary or advisable by my treating physician or their assigned designees.

_____ I understand and agree that I will participate in my treatment plan and my non-adherence to treatment recommendations may result in being terminated as a patient. I also understand that I may discontinue treatment or withdraw my consent to treatment at any time.

_____ I hereby acknowledge that I have received or been provided the opportunity to receive a copy of the HIPPA privacy practices and understand that any questions or complaints may be addressed to the Privacy Officer without penalty.

_____ I authorize my insurance plans to pay directly to Allen Psychiatry the amount due for services rendered to me or the patient covered under the insurance plan. I hereby assign, transfer and set over to Allen Psychiatry all of my rights, title and interest to my medical reimbursement benefits under my insurance plans.

_____ I consent to the release of any medical, mental health, or substance abuse information about the patient required by my insurance company, administrator, managed care company, or review agencies, their employees or agents for the purpose of processing insurance claims for services rendered.

_____ I agree to take full responsibility for the entire amount due for any and all services rendered that are not covered by my insurance carrier. I also acknowledge that I am personally responsible for any deductibles, copays, or any other balance not covered by my insurance carrier. I fully understand that I may not be able to schedule further appointments if my account becomes delinquent or my account is turned over to collections.

Patient Name:

_____

Patient Signature: _____ Date: _____

(Guardian's signature if patient is under 18)

Witness: _____ Date: _____

CHILD AND ADOLESCENT CONSENT (IF APPLICABLE)

I certify that I am the □ parent, □ legal guardian and have legal custody of the above named patient. I hereby consent and give authorization to Allen Psychiatry for the patient to receive treatment. I will be solely responsible for the payment of the patient's treatment and services rendered at Allen Psychiatry. Allen Psychiatry assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements or agreements of any form for the patient's medical care.

Parent/Guardian Name:

_____

Parent/Guardian Signature: _____ Date: _____

Witness: _____Date: _____

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Patient History

Patient Name: _____ Referred By: _____ Date: _____

Chief Complaint: _____

Current Symptoms

Please review the following and check any symptoms that you have been recently experiencing:

☐	Depressed Mood	☐	Inflated Self Esteem/Grandiosity
☐	Sleep Problem	☐	Decrease Need For Sleep
☐	Change in Appetite	☐	Racing Thoughts
☐	Decrease Interest	☐	Pressure to Keep Talking
☐	Decrease Energy	☐	Spending Spree
☐	Difficulty in Concentration	☐	Distractibility
☐	Guilt	☐	Impulsive Behavior
☐	Irritability	☐	Trying to do Way Too Much
☐	Crying Spells	☐	See/Hear Things That May Not be Real
☐	Excessive Worrying	☐	Suspect/Believe Things That May Not be Real
☐	Often Tense/Keyed up	☐	Cannot Stop Repetitive Thoughts
☐	Panic Attack	☐	Cannot Stop Repetitive Behavior
☐	Intrusive/Recurrent Memory of Past Trauma	☐	Hyper Vigilant
☐	Other (Please explain)		

Stressors: _____

Past Psychiatric History

In-Patient Psychiatric Treatment: ☐ No ☐ Yes _____

Out-Patient Psychiatric Treatment: ☐ No ☐ Yes _____

Past Psychiatric Medication: ☐ No ☐ Yes _____

History of Suicide: ☐ No ☐ Yes _____

History of Violence: ☐ No ☐ Yes _____

Substance Abuse History

Average per Day/How long

Alcohol: ☐ No ☐ Yes _____

Tobacco: ☐ No ☐ Yes _____

Illicit Drugs: ☐ No ☐ Yes _____

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Patient Name: _____ Date: _____

Medical History

Primary Care Physician's Name: _____

Do you have any of the following medical problems?

☐ Hypertension	☐ Asthma	☐ Cancer
☐ Heart Disease	☐ Allergies	☐ Migraine Headaches
☐ CHF	☐ Chronic Lung Disease	☐ Seizures
☐ Diabetes	☐ Anemia	☐ Head Injury
☐ Liver Disease	☐ Bleeding Tendency	☐ Stroke
☐ Stomach Ulcers	☐ High Cholesterol	☐ Hypothyroidism
☐ Other Medical Problems:		

Past Surgical History: ☐No ☐Yes _____

Past Hospitalization: ☐No ☐Yes _____

Please list all current medications including over the counter and herbal medications:

_____

_____

Allergies: _____

Family History

Family Medical History: ☐ No ☐ Yes _____

Family Psychiatric History: ☐ No ☐ Yes _____

Social History

Developmental History/Issues: _____
Marital Status/Relationship: _____
Education: _____
Occupation: _____
Religious Affiliation: _____
Legal Issues: _____
Living in: _____ with _____

Patient/Parent/Guardian Signature: _____ Date: _____

Reviewed By: _____ Date: _____

PHARMACY INFORMATION

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR E-PRESCRIBING TO YOUR PREFERRED PHARMACY

PATIENT NAME: _____

PREFERRED PHARMACY NAME: _____

PHARMACY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHARMACY PHONE NUMBER: _____

PHARMACY FAX NUMBER: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____DOB: _____

I hereby authorize disclosure of my medical information to/from the named individual or organization listed below. Please fully complete the form. **Incomplete forms will be null and void.**

□ ALL HEALTH INFORMATION
□ BILLING INFORMATION
□ OBTAIN MEDICAL RECORDS
□ OTHER _____

Purpose for disclosure:
_____

1._____
FULL NAME TELEPHONE NUMBER

_____
ADDRESS

2._____
FULL NAME TELEPHONE NUMBER

_____
ADDRESS

3._____
FULL NAME TELEPHONE NUMBER

_____
ADDRESS

- I understand that specific information to be disclosed may include Drug, Alcohol Abuse or Mental Health Treatment, information regarding communicable diseases including Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency syndrome (AIDS), and other medical conditions, laboratory results, treatment and any other such related information.
- I understand that the information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.
- I authorize that a photocopy of this authorization is acceptable as an original.
- This authorization will remain in effect indefinitely unless revoked in writing. I understand that my treatment is not conditioned upon my providing this authorization. I understand that I have the right to revoke this authorization at any time by providing a written notification to: The Privacy Officer, Healthy Mind World, LLC, 825 Market Street Blvd, Suite 250, Allen, TX, 75013. Healthy Mind World, LLC shall not be deemed responsible for release of any information pursuant to this authorization prior to revocation.
- I understand that there will be a charge for release of photocopies of my medical record. Please indicate below if you need the photocopies of your medical record to be sent to the above named individual or organization.

NAME: _____RELATIONSHIP TO PATIENT_____

SIGNATURE:_____DATE:_____

WITNESS:
_____DATE_____

PLEASE SEND COPIES OF MY MEDICAL RECORD TO THE ABOVE NAMED INDIVIDUAL OR ORGANIZATION.

□ Entire Medical Record
□ Psychiatric Evaluation
□ Other (Please Specify) _____

A charge of $25.00 for the first 20 pages and $0.50 per additional page applies for copying.