Tasmina Sheikh, MD PA

Diplomate of the American Board of Psychology and Neurology
4600 Military Trail, Suite 221, Jupiter, FL 33458
Phone 561-625-9695 Fax 561-625-9745

New Patient Demographics

Last Name_____ **First Name** _____

Date of Birth: _____ **Sex**: *M F (please circle)* **Marital Status**: *Single Married Divorced*

SSN:_____-_____-_____

Address: _____

City:_____ **State**: _____ **Zip**:_____

Primary Phone: _____ *(Home Work Cell)*

Secondary Phone: _____ (*Home Work Cell)*

Email: _____
Is this a secure email that may receive appointment reminders, billing statements/inquiries, or information pertaining to your care? YES NO

Emergency Contact Name:_____ **Phone**_____
Do you consent for us to discuss critical details of your care with your emergency contact? YES NO

Pharmacy Name & Address:_____

Pharmacy Phone: _____

Primary Care Physician Name & Phone:_____

Therapist/Counselor Name & Phone:_____

If the patient is a MINOR:

Parent/Legal Guardian Name:_____

Phone:_____

By signing below, I am attesting that all information provided is true and current to the best of my knowledge.

Patient (or legal guardian) signature_____
Date:_____

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Office Policies

1. HOURS

- Our office is available for appointments Monday-Thursday 9:00 AM to 4:20 PM
- Should you need to make an appointment or speak to our office staff, we enforce the following phone hours: Monday-Thursday: 9 AM-12PM; 1 PM-5PM; Friday: 9AM-1 PM

2. MEDICATIONS

- Medications are to be called in on week days only, absolutely no weekend prescriptions. Please provide at least 3 days notice on all refill requests.
- Controlled substances: No early refills will be allowed, and we will not replace lost or stolen prescriptions. All patients receiving controlled substance prescriptions are subject to prescription drug monitoring through Florida e-forcse program & are subject to random drug testing.
- Sample medications may be issues on a trial basis only. This is done as a courtesy, not an obligation.
- Abuse/Misuse of medications and/or "Dr. Shopping" are absolutely prohibited and warrant discharge. Any persons caught forging or altering a prescription will be reported to the proper authorities. All patients under the care of Dr. Sheikh are subject to controlled substance monitoring through Florida e-forcse system.

3. APPOINTMENTS

- Please keep your scheduled appointment. Reminder calls are a courtesy only, it is the patient's responsibility to remember their scheduled appointment.
- Please contact the office if you will be running more than 15 minutes late, we may need to reschedule your appointment.
- In order to stay active in our system, patients must follow up a minimum of every 6 months. Should a year lapse between appointments, the patient will be treated as a new patient and will be subject to new patient appointment rates.

4. DELAYS

- From time to time, Dr. Sheikh's schedule may be delayed due to unexpected circumstances and/or emergency situations. Please be understanding and compassionate so we may allow appropriate time for each patient.

5. COPAYS/DEDUCTIBLES

- Co-payments, deductibles, co-insurance, or self-pay amounts are due at the time of each visit. All funds will be collected prior to the patient being seen by the physician. All balances, whether they be from prior visits or from office fees, are due at each appointment.
- We currently accept the following forms of payment: Credit/Debit through VISA, MASTERCARD or DISCOVER
- We do NOT accept American Express, cash or checks as a form of payment.

6. FORMS/LETTERS

- Dr. Sheikh reserves the right to refuse to complete any paperwork deemed unwarranted or unnecessary for appropriate patient care. As a matter of office policy, we will NOT complete: Long term disability paperwork or Emotional support animal paperwork.
- Prior authorizations: From time to time a medication that our office prescribes is not covered by the patient's insurance formulary. In these instances, we are happy to attempt a prior authorization, but it is the responsibility of the patient to inform our office directly that a prior authorization is required. Do NOT rely on the pharmacy to contact our office regarding prior authorizations.

7. PATIENT DISCHARGE

- Dr. Sheikh reserves the right to discharge any patient:
  - **i.** Behaving in a rude, inappropriate or disruptive manner
  - **ii.** Any patient that does not comply with recommended patient follow ups or doctor recommendations

I have read and understand the policies of this office and agree to the terms herein.

Patient Signature: _____ Date:_____

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Fees

Here at Dr. Tasmina Sheikh's office we understand how important your time is. We work hard to minimize our patient wait times and to keep our office running on schedule. Please provide at least 24-hour notice if you are unable to attend an appointment. Please anticipate that new patients may be in office up to 1.5 hours and follow ups may be in office up to 1 hour, patients are requested to schedule their days appropriately.

Please be aware of the following policies and fees: (***initial each line to attest that you are aware of the fee)***

1. Any co-pays/coinsurance, out of pocket expenses, or current balances must be paid at check-in, prior to your appointment. _____*initial*

2. If you arrive without any means to pay, we will cancel your appointment and ask you to reschedule (a $25 cancellation fee will be applied to your account). _____ *initial*

3. A $50 office fee will be applied to your account if you cancel a scheduled appointment with less than 24 hour notice. _____ *initial*

4. A $75 office fee will be applied to your account if you do not show up for an appointment and do not provide any notice at all. _____ *initial*

5. A $25 office fee will be applied to your account if you show up more than 15 minutes late to a scheduled appointment without appropriate notification. _____ *initial*

6. Our prescribers will provide enough medication refills to last until your next recommended follow up appointment. Should you miss a follow up appointment and require an interim prescription to be written, a $30 office fee will be applied. NO C-II prescriptions will be written without an appointment. _____ *initial*

7. A $25-$50 fee will be charged for any forms or letters that the doctor or office must complete. _____*initial*

8. Dr. Sheikh allows a maximum of THREE same-day cancellations/ no shows before discharging a patient due to non-compliance. _____*initial*

By signing below, I understand and agree to the above-mentioned fee schedules.

Patient Signature: _____

Date: _____

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Release/Request of Information Consent

*Having properly created and preserved a medical record, a physician must ensure the record remains confidential. Section 456.057(5), Florida Statutes. Nevertheless, the physician must, upon request, furnish the patient or it's legal representative with a copy of "all reports and records relating to [the patient's] examination or treatment… (other than AIDS, mental, and substance abuse records.)," although a psychiatrist or psychologist may substitute a report of the examination in lieu of the medical record. Section 456.057(4), Florida Statutes. Medical records of a psychiatric nature will not be given to patients under any circumstances, unless approved by Dr. Tasmina Sheikh, MD, PA.

PATIENT NAME_____

I GRANT PERMISSION FOR THE RELEASE/REQUEST OF ALL MEDICAL RECORDS INCLUDING LABS, TESTS, REPORTS OF EXAMINATION, ETC… COPIES OF MY MEDICAL RECORDS MAY BE FORWARDED TO OR REQUESTED FROM THE FOLLOWING:
(i.e. Medical Doctor, Therapist, Law Office)

_____ _____

_____ _____

_____ _____

_____ _____

INFORMATION REGARDING MY CASE AND TREATMENT MAY BE DISCLOSED TO/DISCUSSED WITH:
(i.e. Family Member, Friend, Emergency Contact)

_____ _____

_____ _____

_____ _____

_____ _____

I authorize the office of Tasmina Sheikh, MD PA to confirm all scheduled appointments in the following manner: HOME/CELL PHONE, VOICEMAIL, AND/OR EMAIL. _____*initial*

I authorize the office of Tasmina Sheikh, MD PA to inquire about or share (my/the patient's) medication information with the preferred pharmacy on file. _____ *initial*

HIPAA COMPLIANCE NOTICE: I acknowledge that I have been informed of the HIPAA compliant regulations and I am fully aware of my rights with regard to the protection of my medical records and other pertinent information pertaining to my medical care.

Patient/Legal Guardian PRINTED Name: _____

Patient/Legal Guardian SIGNATURE: _____DATE: _____

Witness Signature: _____

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Insurance Authorization

Patient Name: _____

Date of Birth: _____ **Social Security #**: _____

I hereby authorize my insurance company to directly pay Tasmina Sheikh, MD PA the amount due for medical services rendered.

Signature of Insured: _____Relationship to patient:_____

I understand that should my claim not be paid by my insurance company within 90 days, I accept full responsibility for all unpaid balances. I understand that if my account has any unpaid charges that require they be sent to collections, I agree to pay any and all collection fee charges. I understand that if any authorization needs to be obtained in order for my visits to be covered, it is my responsibility to contact my insurance company prior to my visit.

Name of Financially Responsible Party (*print):* _____

Signature of Financially Responsible Party: _____

I hereby authorize Tasmina Sheikh, MD PA to release any pertinent information about my treatment and diagnosis to my medical insurance for claims processing.

Signature of Patient/Legal Guardian: _____ Date: _____

SELF-PAY/UNINSURED PATIENTS

ONLY for patients that are not insured at the time of service or are covered under an insurance plan not accepted by the office of Tasmina Sheikh MD PA. Please ask front office staff for a list of fee schedules for uninsured/self-pay patients.

I understand that I am responsible for all financial charges incurred while I am under the care of the office of Tasmina Sheikh, MD PA. I understand that the office of Tasmina Sheikh will not be billing any insurance for services rendered and all charges will be due at the time of service.

Name of Financially Responsible Party (*print):* _____

Signature of Financially Responsible Party: _____

Tasmina Sheikh, MD PA

MEDICATION LIST

Patient Name: _____

CURRENT MEDICATIONS:

Please list all medications that you are currently taking, including over-the-counter medications/supplements.

It is important to know all medications to avoid any possible drug-drug interactions.

MEDICATION NAME	STRENGTH & DOSAGE	PRESCRIBING PHYSICIAN

PREVIOUSLY PRESCRIBED MEDICATIONS:

Please list all **PSYCHIATRIC** medications that you have been prescribed in the past. This is to include any medications and/or supplements that treat depression, anxiety, sleep, mood, etc.

MEDICATION NAME & DOSE	APPROX DATES PRESCRIBED	RESULT OF MEDICATION (positive/negative effect/reactions)

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Medical History

Patient Name: _____

Do you have any of the following chronic problems:

High Cholesterol	Y / N	High Blood Pressure	Y / N	Cardiovascular	Y / N
Diabetes	Y / N	Seizures	Y / N	Ears/Nose/Throat	Y / N
Nervous	Y / N	Allergic	Y / N	Respiratory	Y / N
Stroke	Y / N	Endocrine	Y / N	Chronic Pain	Y / N
Cancer	Y / N	STDs	Y / N	Autoimmune	Y / N

Other_____

Explain if necessary: _____

Please list any **ALLERGIES** to medications: _____

Please list all prior SURGICAL PROCEDURES:	
Procedure	**Approximate Date**

Have you ever been under the care of a mental health professional in the past? Y / N	
NAME (Please specify psychiatrist, psychologist, therapist/counselor, hospitalist)	**APPROX DATES**

Family History					
Condition	**Y/N**	**Family member(s) affected**	**Condition**	**Y/N**	**Family member(s) affected**
Depression			OCD		
Anxiety			Schizophrenia		
Mood disorder			Substance abuse		
ADD/ADHD			Attempted suicide		
Bipolar disorder			completed suicide		

Do you use cigarettes/other tobacco products? Y / N *Please indicate daily quantity* **1-10 11-20 21-30 30+**
If you smoked previously, please indicate approximately start/quit dates_____
Do you drink alcohol? Y | N *Please indicate daily quantity* **1 2 3 4 5 6+**
Do you smoke marijuana? **Never Rarely Occasionally Frequently Daily**