New Patient Forms

Date: _____

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

Home Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

Home: (____) _____-_____ Cell: (____) _____-_____ Work: (____) _____-_____

Best # to leave a confidential voicemail: Home _____ Work _____ Cell_____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Social Security #: _____ Marital Status: _____

Email Address: _____ Occupation: _____

EMERGENCY CONTACT

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

Home Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

Home: (____) _____-_____ Cell: (____) _____-_____ Work: (____) _____-_____

Relationship: _____

SHADID INTEGRATIVE PSYCHIATRY

Current Medical Providers and Pharmacy Information

PHARMACY: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Fax: _____

PCP: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Fax: _____

THERAPIST: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Fax: _____

OTHER (Psychiatrist, Nutritionist, other Specialist, etc):

_____

Address: _____

City, State, Zip: _____

Phone #: _____

Fax: _____

SHADID INTEGRATIVE PSYCHIATRY

Informed Consent for Assessment and Treatment

Name: _____ Date of Birth _____

I understand that as a patient of Shadid Integrative Psychiatry (SIP), I may receive a range of mental health and wellness services. The type and extent of services that I will receive will be determined following an initial assessment. The goal of the assessment process is to determine the best course of treatment for me. I understand that after the initial assessment process it may be determined that SIP is not the appropriate treatment center for me, and if so this will be communicated to me directly.

I understand that all information shared with the clinicians at SIP is confidential and no information will be released without my consent. During the course of treatment at SIP it may be necessary for my treatment team to communicate with other clinicians. Consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and SIP are bound by law to comply with such requests.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications or supplements may have unwanted side effects.

If I have any questions regarding this consent form or about the services offered at SIP, I may discuss them with my clinician. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by SIP. I understand that either SIP or I may discontinue treatment at any time.

_____ _____

Patient or Guardian Signature Date

Cancellation Policy

The following is a statement of our Cancellation Policy, which we ask that you read and sign. prior to being seen. We understand patients need to cancel and/or reschedule their appointments from time to time. For established patients, full session fee will be charged for cancelled or missed appointments unless 48 hours notice has been given. It is required that a credit card be on file for each patient in the event of a missed appointment or late cancellation.

For new patients, 50% of the new patient appointment fee will be charged at the time of scheduling first appointment. The remaining balance will be charged on the date of service. Appointments cancelled with at least 72 hours notice will receive a full refund of the prepayment. The prepayment will not be refunded for cancelled appointments with less than 72 hours notice or no-shows.

_____ _____

Patient or Guardian Signature Date

SHADID INTEGRATIVE PSYCHIATRY

Financial Policy

The following is a statement of our Financial Policy, which we ask that you read and sign, prior to being seen. For established patients, full payment of the appointment is due at time of service. For new patients, 50% of the new patient appointment fee will be charged when the first appointment is scheduled and the remaining balance will be charged on the date of service. We accept cash, checks, or credit card payment.

Please note that we do not accept any insurance plans. We are Out-of-Network providers with all insurance companies and will not directly bill your insurance company for payment of services. We will provide the necessary paperwork for you to file for reimbursement from your insurance company, if applicable. The invoice will be emailed or mailed to patients on the day of the appointment.

Please be aware that some of the services provided may be "non-covered" services and not considered reasonable and necessary under your insurance plan. You are responsible for payment in full, regardless of your insurance company's final determination of coverage.

I have read this financial policy and agree to all its provisions.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____/_____/_____

Credit Card Authorization

You are not required to fill out credit card information before the New Patient Appointment is scheduled and confirmed with Dr. Shadid. But **you will still need to sign this authorization**, so that when we schedule the appointment, I may be authorized to use your credit card for the appointment fee.

Name on Card: _____

Card Number: _____

Expiration Date: _____

Security Code: _____

Credit Card Type: □ Visa □ Mastercard

Billing Address: _____

City, State, Zip Code: _____

I hereby authorize Shadid Integrative Psychiatry to charge the credit card listed above for payment of service. I certify that I am a person who is authorized to use this credit card.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____/_____/_____