Assistpro, LLC
13885 Hedgewood Drive,
Suite-245,
Woodbridge, VA-22193

Sumera Nadeem M.D.
Board Certified Psychiatrist
Specialized in Psychosomatic Medicine
Ph: 703-490-0336 / Fax: 703-490-4525

PATIENT INFORMATION:

NAME: _____ (*FIRST* *MI* *LAST*)

ADDRESS _____ *APT. NO.* _____

CITY _____ *STATE* _____ *ZIP* _____

BIRTHDATE _____ (*MONTH* *DAY* *YEAR*) *SSN* _____

HOME PHONE ( ) _____

WORK PHONE ( ) _____

CELLPHONE ( ) _____

_____ (*DRIVERS LICENSE NUMBER* *STATE*)

EMAIL ADDRESS: _____

EMPLOYER/OCCUPATION: _____

IN CASE OF EMERGENCY, CONTACT: _____ **RELATIONSHIP** _____

PHONE ( ) _____

PATIENT TREATMENT CONSENT:

- **I authorized the Doctor or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Doctor and mutually agreed upon by me.**
- **I agree to be responsible for payment of all services rendered on my behalf or my dependents.**

Patient / Parent or Guardian Signature: _____ **Date:** _____

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MEDICAL HISTORY

Information that you feel insignificant could be directly related to your health. Answering the following questions will provide is with a thorough understanding of your physical condition for proper recommendations regarding your health care. This information is strictly confidential. Thank you for completing all questions in detail.

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

	YES	NO		YES	NO		YES	N
ANY HEART PROBLEMS	☐	☐	DO YOU SMOKE	☐	☐	ALLERGIC REACTION TO:	☐	☐
HEART MURMUR	☐	☐	LUNG/BREATHING PROBLEMS	☐	☐	PENICILLIN	☐	☐
MITRAL VALVE PROLAPSE	☐	☐	ASTHMA	☐	☐	ERYTHROMYCIN	☐	☐
HEART VALVE DEFECT	☐	☐	BRONCHITIS	☐	☐	SULFA	☐	☐
HEART VALVE REPLACEMENT	☐	☐	EMPHYSEMA	☐	☐	CODEINE	☐	☐
RHEUMATIC FEVER	☐	☐	TUBERCULOSIS	☐	☐	ASPIRIN	☐	☐
ARTIFICIAL JOINT (HP/ KNEE)	☐	☐	SINUS TROUBLE	☐	☐	LATEX	☐	☐
ANGINA	☐	☐	DIFFICULTY IN HEALING	☐	☐	LOCAL ANESTHETIC	☐	☐
STROKE	☐	☐	DIABETES	☐	☐	OTHER MEDICATIONS OR	☐	☐
HEART ATTACK	☐	☐	THYROID PROBLEMS	☐	☐	SUBSTANCES? Please list:	☐	☐
BYPASS	☐	☐	ADRENAL/PITUITARY PROBLEMS	☐	☐	_____		
PACEMAKER	☐	☐	LIVER PROBLEM/DYSFUNCTION	☐	☐	_____		
HIGH BLOOD PRESSURE	☐	☐	HEPATITIS / JAUNDICE	☐	☐	CANCER / TUMOR	☐	☐
LOW BLOOD PRESSURE	☐	☐	KIDNEY PROBLEMS/DYSFUNCTION	☐	☐	OTHER GROWTHS	☐	☐
ANY BLEEDING DISORDERS	☐	☐	STOMACH TROUBLE / ULCERS	☐	☐	CHEMOTERAPHY/RADIATION THERAPHY	☐	☐
ANEMIA	☐	☐	NERVOUS OR MENTAL DISORDER	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐
HEMOPHILIA	☐	☐	EPILEPSY OR SEIZURES	☐	☐	OTHER INFECTIOUS DISEASES	☐	☐
SICKLE CELL TRAIT	☐	☐	ALCOHOLISM	☐	☐	HIV / AIDS	☐	☐
BLOOD TRANSFUSIONS	☐	☐	DRUG ABUSE	☐	☐	ARE YOU PREGNANT?	☐	☐

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Current Symptoms: Please check if you currently experience any of these symptoms:

☐ Irritability ☐ Aggression ☐ High activity level ☐ Starring spells ☐ Trouble expressing self (Please Explain): _____ _____ _____ _____ ☐ Frequent fatigue ☐ Low energy level ☐ Trouble falling asleep ☐ Trouble getting up in morning ☐ Frequent awakenings during the night	☐ Hopelessness ☐ Anxiety ☐ Rage/Anger ☐ Guilt ☐ Grief/Mourning ☐ History of Sexual abuse ☐ History of Physical abuse ☐ Coping with pain (please explain): _____ _____ _____ _____ _____	☐ Self-harm (please explain): _____ _____ _____ ☐ Problem in thinking (please explain): _____ _____ _____ ☐ Problem with memory (please explain): _____ _____ _____
☐ Easily frustrated ☐ Recent weight gain/loss ☐ Recent changes in appetite ☐ Excessive fears/worries ☐ Lack of interest in sexual relationships ☐ Social isolation ☐ Depressed mood ☐ Mood swings	☐ Suicidal thoughts/actions (please explain): _____ _____ _____ _____ ☐ Desire to hurt someone (please explain): _____ _____ _____ _____	☐ History of traumatic events (please explain): _____ _____ _____ ☐ Recent legal charges/police involvement (please explain): _____ _____ _____ ☐ Other (please explain): _____ _____ _____

Relevant Health and Mental Health History:

Physician Name: _____
Physician Phone: _____

Medical or mental health conditions: _____

History of Substance Abuse Problems _____

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Frequency of use of the following:

Alcohol: _____

Caffeine: _____

Nicotine: _____

Other Substances (e.g., marijuana, cocaine, sleeping pills) _____

Previous hospitalizations and date(s) _____

_____

PLEASE DESCRIBE ANY CURRENT HEALTH PROBLEMS NOT LISTED ABOVE _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? ☐ **YES** ☐ **NO** **WHY?** _____

PHYSICIAN'S NAME AND PHONE: _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? ☐ **YES** ☐ **NO**

LIST _____ **FOR** _____ **LIST** _____ **FOR** _____

LIST _____ **FOR** _____ **LIST** _____ **FOR** _____

LIST _____ **FOR** _____ **LIST** _____ **FOR** _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL INFORM THE DOCTOR OF ANY CHANGES IN MY HEALTH STATUS OR MY MEDICATIONS.

_____ _____ _____

DATE **PATIENT / GUARDIAN SIGNATURE** **DOCTOR SIGNATURE**

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NOTICE OF OUR PRIVACY PRACTICES

UNDERSTANDING YOUR HEALTH RECORD & INFORMATION: Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law your health record is the physical property of AssistPro, LLC. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your mental health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your mental health record. You may obtain an accounting of disclosures of your mental health information, request communications of your mental health information by alternative means or at alternative locations, revoke your authorization to use or disclose mental health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES: AssistPro, LLC. is required to maintain the privacy of your mental health information, and in addition, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected mental health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. We will not use or disclose your mental health information without your authorization, except as described in this notice.

PLEASE NOTE:

1. ASSISTPRO LLC WILL NOT PARTICIPATE IN DISABILITY PAPER WORK AND TESTIFY IN COURT PROCEEDINGS AS EXPERT WITNESS.
2. ALSO, ASSISTPOR LLC WILL NOT PARTICIPATE IN ANY COURT PROCEEDINGS

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

***We will use your mental health information for treatment*:** Information obtained by your Doctor will be recorded in your record and used to determine the course of treatment that should work best for you.

We will use your mental health information for payment. For example: A bill may be sent to you. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, relevant history, and treatment given.

Law enforcement: We may disclose mental health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your mental health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public. We will attempt to contact you first to see if you consent to such release.

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Child Abuse: If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services. We will discuss this with you as appropriate.

Abuse of Elderly or Incapacitated Adults: When we have reason to suspect that an incapacitated adult (e.g. someone who is not able to advocate for himself or herself) is being abused, neglected or exploited, we are required by law to make a report and provide relevant information to the Virginia Department of Social Services. You will be notified of this action unless your Doctor believes that it would put you at risk of serious harm.

Judicial or Administrative Proceedings (Court Orders): If you are involved in a court proceeding and a request is made for information about your treatment, we will not release information without your written authorization. If we receive a Subpoena for your records (of which you have been served, along with the proper notice required by state law) we are required to respond. We will attempt to contact you first to see if you consent to such release. If you object, you may file a motion, with the clerk of the court to move to quash (block) the subpoena. If you pursue this, notify your Doctor as soon as possible. We are then required to place your records in a sealed envelope and provide them to the clerk of the court so that the court can determine whether the records should be released.

Serious Threat to Health or Safety of Others: If you communicate to us a specific and immediate threat to cause serious bodily injury or death to an identified or to a readily identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect the threatened person.

Danger to Self: Your Doctor can break confidentiality if you (or your child) are in imminent danger of hurting yourself, in order to keep you (or your child) safe. This may include notifying emergency personnel.

Worker's Compensation: If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant PHI to you, your employer, the insurer, or a certified rehabilitation provider.

Debt Collection: Your name can be reported to a collection agency and/or a credit bureau if you fail to pay your bill. You will be notified before such a report is made.

Legal Defense: Disclosure may be made if a Psychiatrist must arrange for legal consultation if a patient takes legal action against the Psychiatrist

Effective Date: This notice will be effective from April 2018

Modification & Amendment: This notice may be modified or amended by other documents, upon notification from your healthcare provider.

To obtain more information, or if you have any questions about this form, please contact our privacy officer:

Dr. Sumera Nadeem
13885 Hedgewood Drive #245
Woodbridge, VA 22193 (703)490-0336

Consent for Release and Use of Confidential Information
And
Acknowledgement of Notice of Privacy Practices

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I,_____hereby
(Name of Patient or Authorized Agent)

give my consent to AssistPro, LLC to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of:_____

I acknowledge the review and/or receipt of the Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that my doctor has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to my Doctor. I also understand that I will not be able to revoke this consent in cases where the Doctor has already relied on it to use or disclose my mental health information. Written revocation of consent must be sent to our office.

I understand that I have the right to request that the practice restricts how my individually identifiable mental health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Signed:_____Date:_____

If you are not the patient, please specify your relationship to the patient_____.

Policy for Prescription of Benzodiazepines

Benzodiazepines are prescribed for a variety of conditions, particularly anxiety and insomnia. Because benzodiazepines are controlled substances with abuse potential, psychiatrist will perform addiction history before these agents can be prescribed.

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Psychiatrist will not prescribe more than 30 days' supply for benzodiazepines. Urine drug testing may be required in some cases.

Benzodiazepines will need to be taken as prescribed. If a patient runs out of his medication early, refill will not be given and the psychiatrist may decide to discontinue the benzodiazepines.

Patient needs to understand that they cannot sell or give their medication to another individual.

If there is any concern about patient doctor shopping or receiving medications such as benzodiazepines, sedatives or narcotics from other doctors that they have not reported to their psychiatrist, a prescription monitoring program report may be required and their psychiatrist may decide to discontinue prescribing of their benzodiazepines.

You must understand the following:

Benzodiazepine's are highly addictive and create physical dependence.

Alcohol should be not be consumed by patients on benzodiazepines.

Benzodiazepines in combination with narcotics may cause respiratory depression or death

Benzodiazepines are not good long term anti-anxiety medications.

Benzodiazepines may affect the patient's memory and contribute to dementia.

Benzodiazepines contribute to increased risk of falls / accidents.

Patients who take benzodiazepines and drive may be charged with a DUI; this medication interfaces with motor skills and Reaction time.

Benzodiazepines can cause teratogenic effects and will not be prescribed if a client is pregnant.

Abruptly stopping a Benzodiazepine may cause seizures or death.

I understand that medication alone is not sufficient treatment for my condition, and I will need to participate in therapy and Other treatments as discusses with my psychiatrist and specified in my treatment plan.

I understand that my psychiatrist may decide to taper and discontinue my Benzodiazepines without my agreement.

I have read and understand the policies listed above.

Patient Name _____

Patient Signature _____

Date: _____

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Financial Agreement

Your financial obligations:

Fees:

- The fee for an initial consultation is $250.00
- The fee for Follow Up appointment is $125.00
- All fees are payable at the time of service. (Cash/Check/Visa/Master cards only).

Cancellation Policy:

You have 24 hours prior to your scheduled appointment to cancel the appointment without being charged. If you do not provide 24 hour notice, you are responsible for an administrative fee of $50.

Failure to provide payment for services, including missed appointment charges, will result in termination of future appointments. Any outstanding balances will be reported to a collection agency.

I have read and understand the above. I agree to provide payment in full.

Print Name:---------- Patient Signature:----------

Date:----------

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CREDIT CARD ON FILE POLICY

We require keeping your credit or debit card on file as a convenient method of payment for which you are liable.

Your credit card information is kept confidential and secure.

I authorize to charge my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number _____

Expiration Date _____ **/** _____ **/** _____ **CVV** _____ **(3 digits on back of card)**

Cardholder Name _____

Signature _____

Billing Address _____

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

I (we), the undersigned, authorize to charge my credit card, indicated above, for balances due for services rendered.

This authorization will remain in effect until I (we) cancel this authorization.

Patient Name (Print): _____

Patient Signature: _____

Date: __ / __ / __