FRISCO BEHAVIORAL HEALTH GROUP, LLC

Farah Ali, M. D.

4500 Hillcrest Road Suite 115

Frisco, Texas 75035

Tel. (469) 213.6400 Fax. (469) 213.6473

PATIENT INFORMATION

First Name	Middle Name	Last Name	Sex ☐ Male ☐ Female
Street Address		Birthdate / /	Age
City	State	Zip Code	Home Phone
Cell Phone	Email address		Okay to leave voice mail ☐ Yes ☐ No

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to Patient:
Emergency Contact Number:	Do we have permission to contact them regarding your appointments, billing or in case of emergency? ☐ Yes ☐ No

THE FOLLOWING INFORMATION MUST BE COMPLETED

PATIENT	INSURER / RESPONSIBLE PARTY
Name:	Name:
Employer:	Employer:
Work Phone:	Address if different than patient:
Best phone contact #:	
Email Address (Okay to contact by email) ☐ Yes ☐ No	Relationship to patient:

____

Who referred you to Frisco Behavioral Health Group, LLC?

____

Current Medications/Dosage/Physician

____

Briefly state your reason for this visit

NOTE: Payment is expected at the time services are rendered. Failure to provide us the information requested may result in a reduction or denial of payment by your insurance.

FRISCO BEHAVIORAL HEALTH GROUP, LLC
Farah Ali, M. D.
4500 Hillcrest Road Suite 115
Frisco, Texas 75035
Tel. (469) 213.6400 Fax. (469) 213.6473

PATIENT HEALTH QUESTIONNAIRE

Patient's Name: ____ Date: ______________________

	Not at all	Several Days	More than half the days	Nearly every day
1. Over the last 2 weeks, how often have you been Bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowing that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of Hurting yourself in some way.	☐	☐	☐	☐

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

____
Signature

RECIPROCAL CONSENT TO EXCHANGE INFORMATION AND RECORDS

Client's Name: ____, Date of Birth: _____/_____/______

I, ____, hereby consent to the release of privileged information and records and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation and authorize:

Frisco Behavioral Health Group, LLC
Farah Ali, M.D.
4500 Hillcrest Road - Suite 115
Frisco, Texas 75035
(469) 213.6400
and

____
Name

____
Address

____ ____
Phone Fax

To exchange reciprocal information and records for the purpose of clarifying and enhancing my care and treatment including but not limited to:

________________ Psychiatric Evaluation
________________ Psychological and / or Academic Testing
________________ Diagnosis, Treatment Plan and Progress Notes
________________ Parent Consultations (if the client is a minor)
___________Other ____________________________________

Farah Ali, M.D. is hereby released from all liability arising out of, or in any way incidental to, producing records or providing information pursuant to this authorization. (A duplicate, photo static copy or facsimile reproduction of this authorization may be used in lieu of the original.) This authorization is subject to revocation in writing only by the undersigned.

Signature: _______________________________Print Name: _____________________________________

Relationship to client: _________________________________ Date: ______________________________

FRISCO BEHAVIORAL HEALTH GROUP, LLC
Farah Ali, M. D.
4500 Hillcrest Road Suite 115
Frisco, Texas 75035
Tel. (469) 213.6400 Fax. (469) 213.6473

Please read and initial the following statements concerning our office policies:

_____ I certify that the information I have given on this form is true and correct to the best of my knowledge.

_____ I understand that if I arrive more than 10 minutes late for an appointment, it is not guaranteed that I will be seen. A $75.00 no show fee will be charged for this appointment if the schedule does not allow for you to be seen.

_____ I understand that payment is required at the time services are rendered and I assume responsibility for this. I understand there is a $30.00 fee for all returned checks.
(*Note to divorced parents: Payment is the responsibility of the parent that brings the child into the office for treatment regardless of the divorce decree. The divorce decree is a matter between the divorced parents and the courts and we cannot be placed in the middle*

_____ I understand that insurance will only be filed with insurance companies that Frisco Behavioral Health Group, LLC and Dr. Ali is contracted with. In order to achieve this, please have all current insurance information on file. I understand that secondary insurance will not be filed.

_____ I understand that if there are any changes in my insurance coverage, I will notify the business office at least five (5) days prior to my next appointment or the visit will be self-pay or rescheduled.

_____ I understand that all information obtained in regards to my insurance coverage is not a guarantee of payment by my insurance company. The amount collected at the time of service is only an estimate. I understand that I am ultimately responsible for any and all balances on my account.

_____ I understand it is my responsibility to keep my appointments. If I am unable to keep my appointments, I will notify the office at least 24 hours in advance. I understand that I will be charged $75.00 for the time reserved if I do not call and cancel or reschedule at least 24 hours prior to my scheduled appointment.

_____ I understand that regular office hours for FBHG are Monday – Friday, 8:30 am – 5:00 pm.

_____ I understand it is my responsibility to keep track of my medication supply. I understand that I should request refills during regular office hours and that request received outside regular business hours will not be called into the pharmacist until the next business day.

_____ I understand that my records are protected by special laws governing psychiatric/substance abuse records and that I must sign a "Release of Information" form before any records can be released.

I hereby authorize Farah Ali, M. D. to provide psychiatric services to: ☐ me ☐ my child

____ _____________________________________
Signature of Patient or Parent (if patient is a minor) Date

FRISCO BEHAVIORAL HEALTH GROUP, LLC
Farah Ali, M. D.
4500 Hillcrest Road Suite 115
Frisco, Texas 75035
Tel. (469) 213.6400 Fax. (469) 213.6473

AUTHORIZATION FOR THE RELEASE OF INFORMATION
(INSURANCE CARRIER)

I do hereby consent and authorize Frisco Behavioral Health Group, LLC to release all information contained in my financial and medical records, including diagnoses and test results, to my insurance company or health plan, their agents and independent contractors, or any other person or entity that is responsible for paying or processing for payment any portion of my bill, for the purposes of administration, billing and quality and risk management. This consent applies to all records created in the course of and relating to my treatment and for the purpose of reimbursement for treatment.

I understand that I may revoke this consent at any time by giving written notice to the Frisco Behavioral Health Group, LLC except to the extent that action has been taken in reliance thereon. If no prior notice of revocation is received, this consent will expire six (6) months after the date of patient discharge from treatment, unless another date or condition is specified.

Optional: Specified date ___________________, or event/condition__________________________________.

I understand that I have the right to inspect and copy the information to be disclosed.

I understand that if I refuse to consent to this Release of Information, the consequences will be that the insurance claim will not be filed.

____
Signature of Patient or Parent/Guardian Date

____
Signature of Witness Date

Notice to Receiving Agency/Person

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug use patient.

FRISCO BEHAVIORAL HEALTH GROUP, LLC

Farah Ali, M. D.
4500 Hillcrest Road Suite 115
Frisco, Texas 75035
Tel. (469) 213.6400   Fax. (469) 213.6473

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my or my child's insurance company to pay directly to Frisco Behavioral Health Group, LLC / Farah Ali, M. D. any insurance benefits otherwise payable to me or my child, if any by reason of the services described in the itemized statement rendered, and subject to the terms and limitations found in my insurance policy with the aforementioned company. THIS IS A DIRECT ASSIGNMENT OF RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assigned, and I have agreed to pay in a current manner any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

______________________________	______________________
Signature of Insured or Insured Representative	Date
______________________________	______________________
Signature of Patient	Date
______________________________	______________________
Signature of Witness	Date

THIS AREA LEFT BLANK INTENTIONALLY

FRISCO BEHAVIORAL HEALTH GROUP, LLC

Farah Ali, M. D.
4500 Hillcrest Road Suite 115
Frisco, Texas 75035
Tel. (469) 213.6400   Fax. (469) 213.6473

ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES

Patient Copy

YOUR RIGHTS

- To be treated with dignity and addressed in a respectful manner.
- Consistent, quality care by qualified and trained professionals in a clean and safe setting.
- Humane care and treatment free of abuse, neglect, humiliation, threats or exploitation.
- Privacy of your treatment and your records.
- To be informed of risk, benefits and alternatives to medications and/or therapy.
- To consult with another licensed practitioner at your own expense.
- To make a complaint or grievance.
- The same legal rights and responsibilities as all citizens, unless otherwise indicated by law.
- The right to be free from discrimination due to race, color, religion, national origin, gender, disability, sexual orientation or marital status.

YOUR RESPONSIBILITIES:

- Please notify your provider immediately of any concerns, questions or feedback you may have regarding your sessions and your care
- Keep appointments and when unable to do so for any reason, **notify your counselor or physician's office with at least 24 hours' notice prior to your appointment. You will be charged $75.00 for appointment cancellations without 24 hour notice.**
- To pay a fee of $15.00 for any medications if required on the same day.
- To pay a fee of $30.00 for treatment reports you request on your behalf and/or for copies of your records.
- All co-pays, fees or charges will be collected at the time of service. There is a $30.00 fee for all returned checks.
- To maintain a clean and safe office environment – avoid bringing any food or drinks into the clinic.
- To maintain safe settings by not bringing weapons, non-prescribed drugs or alcohol on the premises of the clinic.
- Treat your provider, office staff and furnishings with respect and follow all posted office rules.
- Maintain supervision and responsibility for your children and family while in the office.
- Pay for any damages caused by the careless, reckless or intentional behavior of you or your family members.
- Provide accurate and complete information about current problems, past illnesses and treatments and other pertinent information.
- Inform us if you are receiving counseling, medications or other therapeutic services from another clinician.
- Participate in treatment decisions and follow the agreed upon plan or recommendations.
- Check with your counselor or physician's office about your appointment if inclement weather is forecasted.
- You may be referred to another provider for failing to follow these responsibilities.

FRISCO BEHAVIORAL HEALTH GROUP, LLC

Farah Ali, M. D.
4500 Hillcrest Road Suite 115
Frisco, Texas 75035
Tel. (469) 213.6400   Fax. (469) 213.6473

ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES
Office Copy

YOUR RIGHTS:

- To be treated with dignity and addressed in a respectful manner.
- Consistent, quality care by qualified and trained professionals in a clean and safe setting.
- Humane care and treatment free of abuse, neglect, humiliation, threats or exploitation.
- Privacy of your treatment and your records.
- To be informed of risk, benefits and alternatives to medications and/or therapy.
- To consult with another licensed practitioner at your own expense.
- To make a complaint or grievance.
- The same legal rights and responsibilities as all citizens, unless otherwise indicated by law.
- The right to be free from discrimination due to race, color, religion, national origin, gender, disability, sexual orientation or marital status.

YOUR RESPONSIBILITIES:

- Please notify your provider immediately of any concerns, questions or feedback you may have regarding your sessions and your care
- Keep appointments and when unable to do so for any reason, **notify your counselor or physician's office with at least 24 hours' notice prior to your appointment. You will be charged $75.00 for appointment cancellations without 24 hour notice.**
- To pay a fee of $15.00 for any medications if required on the same day.
- To pay a fee of $30.00 for treatment reports you request on your behalf and/or for copies of your records.
- All co-pays, fees or charges will be collected at the time of service. There is a $30.00 fee for all returned checks.
- To maintain a clean and safe office environment – avoid bringing any food or drinks into the clinic.
- To maintain safe settings by not bringing weapons, non-prescribed drugs or alcohol on the premises of the clinic.
- Treat your provider, office staff and furnishings with respect and follow all posted office rules.
- Maintain supervision and responsibility for your children and family while in the office.
- Pay for any damages caused by the careless, reckless or intentional behavior of you or your family members.
- Provide accurate and complete information about current problems, past illnesses and treatments and other pertinent information.
- Inform us if you are receiving counseling, medications or other therapeutic services from another clinician.
- Participate in treatment decisions and follow the agreed upon plan or recommendations.
- Check with your counselor or physician's office about your appointment if inclement weather is forecasted.
- You may be referred to another provider for failing to follow these responsibilities.

ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES

Page 2

I acknowledge that I have reviewed and was given the opportunity to receive a copy of these **RIGHTS AND RESPONSIBILITIES.**

____ ______________________________
Printed Name of Patient Date

____ ______________________________
Signature of Patient, Parent or Guardian Date

NOTICE CONCERNING COMPLAINTS

Complaints May Be Reported To:

Texas State Board of Medical Examiners
ATTN: Investigations
1812 Centre Creek Drive Suite 300
P. O. Box 149134
Austin, Texas 78714-9134

THIS AREA LEFT BLANK INTENTIONALLY

FRISCO BEHAVIORAL HEALTH GROUP, LLC

Farah Ali, M. D.
4500 Hillcrest Road Suite 115
Frisco, Texas 75035
Tel. (469) 213.6400 Fax. (469) 213.6473

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered the opportunity to review and receive a copy of the Personal Health Information and notice of Privacy Practices which explains how my medical information will be used and disclosed.

____ ___________________________
Signature of Patient or Personal Representative Date

____ ___________________________
Printed Name of Patient or Personal Representative Date

____ ___________________________
Description of Personal Representative’s Authority Date

THIS AREA LEFT BLANK INTENTIONALLY

FRISCO BEHAVIORAL HEALTH GROUP, LLC

Farah Ali, M. D.
4500 Hillcrest Road Suite 115
Frisco, Texas 75035
Tel. (469) 213.6400   Fax. (469) 213.6473

PATIENT NARCOTIC & ADHD MEDICATION

____
Patient's Printed Name

1. I understand that the medication I am prescribed for ADHD is a Class II Narcotic and the medication I am prescribed for sleep, anxiety is a Class IV narcotic.
2. I understand that the medication cannot be refilled before thirty (30) days.
3. I understand that if I lose my prescription, I will have to wait until the last due date from the original due date the last prescription was written for a refill.
4. I understand the medication is for my use only and cannot be shared with anyone else.
5. I understand that I am subject to random drug testing.
6. I understand that I will only take the medication as prescribed.
7. I understand that I cannot take illegal street drugs with this medication and if illegal drugs are found in my system with drug testing this medication will not be renewed by my provider.

____   _________________________
Patient's Signature   Date: