DESAI HEALTH

8823 San Jose Blvd., Ste. 301, Jacksonville, FL 32217
PH: (904) 638-8164 FAX: (904) 379-4736

PATIENT INFORMATION FORM

Patient Name (please print):_____ DOB:_____ Sex (M/F): _____

Service Requested:
_____Medication Management (MD/ARNP to evaluate/treat with use of medications)
_____Psychotherapy (licensed mental health counselor to evaluate/treat without the use of medications)
_____Both Medication Management and Psychotherapy

DEMOGRAPHIC AND INSURANCE INFORMATION

Address: _____

City: _____ State: _____ Zip Code:_____

Main Phone No.: _____ email: _____

Responsible Party (if minor or other than patient):

Name: _____ Relationship to Patient: _____

Address (if other than patient's): _____

Primary Insurance Name: _____ Policy ID#: _____

Insured/Subscriber Name: _____ Insured/Subscriber DOB: _____

Secondary Insurance Name: _____ Policy ID#: _____

Insured/Subscriber Name: _____ Insured/Subscriber DOB: _____

PERSONAL/MEDICAL HISTORY

Marital Status: _____Single _____Married _____Divorced _____Widowed _____ Other: _____

Employment Status: _____ Full-Time _____Part-Time _____ Student at _____

Living Arrangements (who do you live with?)_____

Are you currently taking any supplements or over-the-counter medications (including herbs or vitamins)? □ YES □ NO

If yes, please describe: _____

Do you smoke cigarettes or use tobacco products (including "vaping" or e-cigarette)? □ YES □ NO

(if "yes," how much and for how long) _____

Do you drink coffee/caffeinated beverages? □ YES □ NO (If yes, how often): _____

Do you drink alcohol? □ YES □ NO (if "yes," how much and how often) : _____

MEDICAL HISTORY, Cont'd

Drug use? (Marijuana, Cocaine, Pain Pills, etc.) Please list: _____

Are you currently taking any prescription medication(s)? □ YES □ NO (if "yes" please list below)

Medication Name	Dosage	Frequency	Reason Prescribed	Prescribed By	Tolerance/Reactions

Are you allergic to or have you ever had an adverse reaction to any food, medication, or other substances? □ YES □ NO

Pease list all known allergies or sensitivities: _____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Have you ever been treated for a psychiatric/psychological condition? □ YES □ NO (if "yes" please describe below):

_____

_____

_____

Have you ever had any psychiatric hospitalizations? □ YES □ NO (if "yes" please indicate below)

Treatment Date(s)	Facility	Reason for Treatment	Duration	Outcome and Follow-Up Care

Please describe any psychiatric history of family members: _____

_____

_____

REASON FOR VISIT (THIS MUST BE COMPLETED)

Please describe, in detail, the reason you are seeking care. Include any symptoms and when they started: _____

_____

_____

_____

_____

CONSENTS AND AUTHORIZATIONS

CONSENT TO TREAT: I hereby consent to examination and treatment by my health care provider at the office of Chirag V. Desai, MD, LLC (dba Desai Health). I understand that my healthcare provider may access medical information about my medication use from electronic prescribing software and databases. I hereby affirm that I am of legal age and otherwise competent to consent to medical treatment. If not, the person signing below represents that such person as the parent, legal guardian or person otherwise allowed by law to consent to the examination and treatment of the patient and by their signature hereto consents.

Signature of Patient or Responsible Party _____ Date: _____

If signed by other than patient, please print name: _____ Relationship to patient: _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I hereby authorize the office of Chirag V Desai, MD, LLC (Desai Health) to bill my insurance for services rendered and to release any information that may be required to secure payment for charges incurred by me or on my behalf. I authorize payment directly to my provider of any insurance benefits otherwise payable to me and in the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to Chirag V Desai, MD, LLC (Desai Health). I also authorize the release of any information to county, state, or federal public health agencies, as required by law.

Signature of Patient or Responsible Party _____ Date: _____

If signed by other than patient, please print name: _____ Relationship to patient: _____

ADMINISTRATIVE AND FINANCIAL AGREEMENT

If you have insurance, we will make every effort to assist you with your carrier to make sure your treatment is authorized and reimbursement Is received. However, our professional services are rendered to you, not the insurance company. Therefore, payment for services is ultimately your responsibility. If your insurance company fails to pay, for any reason, it is your responsibility to pay for services rendered and such payment is not contingent on settlement, judgement, or insurance payment by which you may recover said fees.

ALL CO-PAYMENTS ARE TO BE PAID AT THE TIME OF THE VISIT. Any exceptions are at the discretion of the provider and will need to be agreed to prior to being seen. Applicable deductibles may be required at the time of the visit or may be billed to you after insurances has processed. If you fail to make timely payments on your account, as agreed upon, your account will be turned over to a collection agency and you will be assessed a 30% collection fee. If your account is placed with a collection agency you will be discharged from the practice.

Our office must be notified of any insurance changes PRIOR to your next appointment so that we can verify eligibility and benefits. If you do not inform us of any changes, you will be responsible for any charges not covered by your insurance company.

There is a $50 fee for all returned checks. Returned checks are not re-deposited and if not paid may be turned over to a collection agency of the State Attorney's office. After your 2nd returned check we will require payment in the form of cash or credit card only.

Self-pay patients are billed per amount of time scheduled and payment is expected prior to seeing your provider. In case of late arrival, you will still be billed for the full amount of time originally scheduled.

Self-pay Fees:

Evaluation:	M.D. = $300	Ph.D./APRN = $250	LMHC/LCSW = $200
Follow-up visits:	M.D. = $140	Ph.D./APRN = $120	LMHC/LCSW = $150
Phone Consults:	M.D. = $65 per 10 mins	Ph.D/APRN = $55 per 10 mins	LMHC/LCSW = $25 per 10 mins
Letters/Forms:	$25 and up (based on complexity and time spent on completion)		

Signature of Patient or Responsible Party _____ Date: _____

If signed by other than patient, please print name: _____ Relationship to patient: _____

OFFICE POLICIES

In order to facilitate your care, we have developed certain policies and procedures that we feel are important in establishing a working partnership. Please read these policies carefully; Your signature on the last page acknowledges your understanding of these policies and is required for treatment to commence. Thank you.

Our office is a scent-free zone. The chemicals used in scented products can make some people sick, especially those with fragrance sensitivities, asthma, allergies and other medical conditions. Help us keep the air we share healthy and fragrance-free by not wearing perfumes, lotions and other fragrances when visiting our office.

APPOINTMENTS

1. You are expected to arrive for your appointment 5-10 minutes early to complete the check-in process and address any issues, prior to being seen. As a courtesy to our patients, we offer an appointment reminder service. However, if for any reason our office fails to call you, you are still responsible for keeping the appointment.

2. Please provide 24-hours' notice to CANCEL appointments. For Monday appointments (or Tuesday if Monday is a holiday), cancellations must be made by NOON the Friday prior to the weekend. *Cancellations with less than 24-hour notice and appointment no-shows will be assessed a fee equal to the self-pay rate (see the Administrative and Financial Agreement section). These fees must be paid prior to your next scheduled visit; waiver of any fees will be at the provider's discretion only.*

PRESCRIPTIONS AND MEDICATIONS

1. Refill requests require **three (3) business days** to process and are NOT processed on weekends or holidays. **There is NO guarantee that urgent demands for refills will be met within this three-day window.** We do not accept refill requests from pharmacies, and all such requests will not be acknowledged. PLEASE ASK YOUR PHARMACY TO TAKE YOUR PRESCRIPTIONS OFF THEIR AUTO-REFILL SYSTEM.

2. If you require refills due to missed appointments, or lost prescriptions, a fee may be charged. Refills may be denied if you have not been seen in over FOUR months. You may need to be seen for re-assessment before medications can be prescribed.

3. Your provider may choose not to prescribe Benzodiazepines (i.e., Xanax, Valium, Ativan, etc). If prescribed, you may be required to submit to drug testing. Patients who misuse, overuse, or abuse any medications will be discharged from the practice.

4. Always take your medication as prescribed. Do not change the dosage or discontinue any medication without your provider's permission. If your medication makes you feel worse, or in the case of an adverse reaction, call our office immediately or go to the nearest emergency room.

TREATMENT AND CONTINUITY OF CARE

1. To ensure adequate medical oversight and practice in accordance with the accepted standards of care, you agree to be seen for all follow-up appointments at least every three to four months. Noncompliance with your provider's treatment plan and/or recommendations, or laboratory monitoring while taking medications, will result in discharge from the practice.

2. If you have not been seen in six (6) months or more, your chart will be closed and you will be discharged from the practice. A return to care would be at the discretion of, and upon approval from, the rendering provider.

3. If two appointments in a row are missed, without explanation, any remaining scheduled/standing appointments will be cancelled, and you may be discharged from the practice.

4. A parent or guardian MUST be present at the time of any minor child's medication management appointment. Medication changes cannot be made without parental consent.

5. We do not provide forensic psychiatry services and will not get involved in custody or other court-related matters. If any of our providers are subpoenaed to appear in court you will be responsible for their hourly rate and any associated legal fees.

MESSAGES, EMERGENCIES, AND AFTER-HOURS CALLS

1. In case of emergency call 911 or go to the nearest emergency room. Our office is **NOT** equipped to handle any type of emergency. **DO NOT** come to our office if you feel the situation is dire.

2. If you have **non-emergent** concerns after hours, you can leave a message that will be checked the next business day. In general, if there is an emergency, you will be told to go to the ER or call 911.

3. Messages are checked every couple of hours, on workdays, when the office is open; you will have advance notice, if possible, of office closures. **Calls are returned according to clinical acuity.**

4. If any provider, or employee, calls you from their personal cell phone, and you are able to obtain the phone number, **DO NOT** use that number for **any** reason. We ask that you always contact the office with appointment and refill requests or clinical concerns. Do not text, email, or leave messages on anyone's personal cell phone, as those messages will not be acknowledged.

5. None of the providers at Desai Health are associated with, or have admitting privileges, to any hospital. We do, however, try to collaborate with hospital staff if you are admitted for psychiatric treatment. Keep in mind: we must be notified of your admission to participate in care coordination. If a psychiatric hospitalization occurs, please notify our office – do not rely on hospital staff to contact us.

I hereby attest that I have read and understand the information provided to me regarding the Office Policies, and I agree to abide by these terms and conditions. I understand that if the above policies are not adhered to, the providers at Desai Health will not be able to provide my care and I may be discharged from the practice.

Signature of Patient or Responsible Party _____ Date: _____

If signed by other than patient, please print name: _____ Relationship to patient: _____

DESAI HEALTH

CREDIT CARD AUTHORIZATION FORM

Name of Patient: _____ DOB: _____

Credit Card Type: ___VISA ___MASTERCARD ___AMERICAN EXPRESS ___ DISCOVER

Credit Card Number: _____

Expiration Date: _____ CVV: _____

Name as it appears on the card: _____

Billing Address for Credit Card:

Street: _____

City, State: _____

Zip Code: _____

Phone Number: _____

I authorize Chirag Desai, MD, LLC (dba Desai Health) to charge this credit/debit/HSA card for any and all copays, deductibles, co-insurance, patient responsibility portions of my insurance (if applicable), fees for the completion of forms and/or letters, prescription refills, lost prescriptions, and missed/no show or late appointment fees.
I certify that I am an authorized signer on this card and that the card number and signature below are the same as those on file with the issuer of the card.

Cardholder Signature: _____ Date: _____