CRESCENT PSYCHIATRY
Sabahat Faheem, M.D.
509 Westpark Way, Suite#110 Euless TX 76040-3991
Phone (817) 571-3800 Fax (817) 571-3802

GENERAL PATIENT INFORMATION (Please Print)

Patient Name: _____

Date of Birth: _____ Sex: (Circle One) Male/ Female

Street Address: _____

City/State: _____ Zip: _____

Cell Phone: _____Home Phone: _____

Email Address: _____

Occupation: _____

Patient's Employer, Address, and Phone: _____

Emergency Contact Name and Phone #: _____

Marital Status: (Circle One) Single / Married / Divorced / Other

Spouse's Name: _____ Cell Phone:_____

INSURANCE INFORMATION (Please Allow Us to Make a Copy of Your Insurance Card and Driver's License)

Primary Insurance: _____

Patient's ID #: _____ Group#: _____

Insurance Phone: _____ Policy Holder Name: _____
Is there another health insurance benefit plan? _____ Yes_____ No

If yes, please complete information below:

Secondary Insurance:

Insurance Company: _____

ID#: _____ Group#: _____

Insurance Phone #: _____ Policy Holder Name:_____

What is the reason for this visit?

_____
_____

Current medications:

_____
_____
_____

ALLERGIES: 1-Name of the medicine_____

Severity: Mild / Moderate / Severe. What was the reaction?

2-Name of the medicine_____

Severity: Mild / Moderate / Severe, what was the reaction?

PHARMACY: _____

Phone: _____

Address: _____

Primary care physician and number: _____

CONSENT TO RECEIVE TEXT MESSAGES:

By signing below and providing my wireless phone number to the Crescent Psychiatry staff, I agree and acknowledge that Crescent Psychiatry doctors or staff may send text messages to my wireless phone number. I agree that these calls may be regarding my appointment reminders or other health related matters. I acknowledge that this consent may be removed any time at my request. However, until such consent is revoked, I may receive text messages from Crescent Psychiatry at my wireless number.

Patient's name: _____

Signature:_____Date:_____

ASSIGNMENT AND RELEASE:

I understand that I am financially responsible for payment of all co-pays, coinsurance amounts, deductibles, and/or noncovered services that are not paid by my insurance company.

Patient's name: _____

Signature: _____Date: _____

NEW PATIENT ACCEPTANCE POLICY:

This is to inform the patient about the services provided by the office of Dr. Sabahat Faheem. By signing the bottom of this statement, you are acknowledging that you are aware of office policy for accepting new patients. Patient/Doctor can deny ongoing establishment in our office. The office will determine if the patient can continue treatment after the initial visit. After you are an established patient, this office may terminate a patient with one month notice because of unavoidable circumstances. I have read and understand the information presented to me.

Patient's name: _____

Signature: _____Date:_____

CONSENT TO PROVIDE MENTAL HEALTH TREATMENT AND CARE:

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to the mental health treatment, as ordered by the psychiatrist, medical care and treatment as provided through Crescent Psychiatry on an outpatient/ office visit. This consent includes all mental health services rendered under the general or specific instructions of the provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), or the designees under the direction of a physician, as deemed reasonable and necessary. I agree and acknowledge that Crescent Psychiatry is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments at Crescent Psychiatry Mental Health Clinic. Telemedicine, I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

Patient's name: _____

Signature: _____Date:_____

CLIENT RESPONSIBILITIES AND RIGHTS:
You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

This statement is prepared to give you information regarding the client rights and responsibilities. By signing at the bottom of this statement, you are acknowledging that you are aware of your rights and responsibilities as a recipient of services.

The doctor will not publish, communicate, or otherwise disclose information in any records without your signed consent (on a release of information form) except in any case in which there appears to be a clear and imminent danger to yourself or another individual or if such records are required to be released for court proceedings. The doctor is also required by professional ethics and the laws of the State of Texas to report any potential or actual suspicion of abuse or neglect of a minor child or the elderly.

I authorize Crescent Psychiatry / Sabahat Faheem MD to exchange information regarding my mental health care, substance abuse treatment, or other medical or clinical information. I understand that this consent will remain in effect for one year or throughout my treatment. I may revoke this authorization at any time by written notice to the Crescent Psychiatry.

I have read and understand the information presented to me. I agree to honor the terms of this agreement. I agree to be responsible for the fee incurred or co-payment due at the time of session, and I understand that if my insurance refuses to pay I am responsible for full payment.

Patient's name: _____

Signature: _____Date:_____

NEW CRESCENT PSYCHIATRY NO-SHOW AND CANCELLATION POLICY.
It is patient responsibility to give us at least 3 business days notice for any cancellations or reschedules. If you CANCEL or RESCHEDULE your appointment without a 3 business days notice we will charge a $100 "no show/cancellation" fee. You will directly be charged for it and will have to pay on your next visit. It is very important that you keep your scheduled appointment with us. After three no-shows/cancellations to your appointments, our practice may decide to terminate its care with you.

Patient's name:_____Patient signature_____Date:_____

PATIENT TREATMENT CONTRACT:

As a participant in treatment, I freely and voluntarily agree to accept this treatment contract as follows:

1. I consent to treatment by my providers.
2. I agree to keep and be on time to all my scheduled appointments to the best of my ability.
3. I agree to adhere to the financial policy outlined by this office.
4. I agree to conduct myself in a courteous manner in the doctor's office.
5. I agree not to sell, deal, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated.
6. I agree not to steal, or conduct any illegal or disruptive activities in office.
7. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
8. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
9. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
10. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
11. I understand that as part of my treatment plan it is required that I see the physician on a regular basis as part of my treatment and no prescriptions will be written without an office visit. Subsequently I understand that if I do not keep appointments regular with my provider and a period of 60 days elapses, I may be discharged as a patient from care.
12. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
13. I understand that I may be screened for drug abuse or use at any time.

Patient's name:_____

Patient signature_____Date:_____