CONFIDENTIAL

Transcultural Care
Olamide Alabi, PMHNP-BC
415 Highway 6 West, Oxford, MS 38655
Phone 662 234 5317 Fax 662 638 3880

Patient Registration Information

Last Name: _____First Name: _____Middle Initial: _____

Preferred Name: _____SSN _____ DOB: ___/___/_____ Gender: M ___ F ___ Other ___

Address:_____City:_____State:_____Zip:_____

Mailing Address (If Different Than Above): _____

Primary Phone: _____ Can we leave a detailed voicemail on this line (circle one)? Yes / No

Work phone: _____ Can we leave a detailed voicemail on this line (circle one)? Yes / No

Place of Employment: _____ Please circle one: Full time Part time

Email: _____

Primary Care Provider: _____ Phone:_____

Who were you referred by?: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Emergency Contact Relation: _____

Billing Address: Check if same as above ( )

Last Name: _____First Name: _____Middle Initial: ____

Relationship to patient: _____

DOB _____ Driver's License _____State_____

Address:_____City_____State_____Zip_____

Mailing Address (if different from above) _____ City_____State_____ Zip_____

Primary Phone: _____ Message Ok? Yes / No Work phone: _____

I acknowledge that I have received a copy of Zaurov Psychiatry's Privacy Practices (otherwise known as HIPPA).

Patient name or guardian/parent: _____ Date: _____

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Confidentiality and Informed Consent for Treatment

Clinical records are confidential. Information about your treatment will not be released without your written permission with a few exceptions. Nurse Practitioners are required by law to report evidence of suicidal or homicidal intent, evidence of past or current child abuse, and evidence of past, or current elder abuse. Confidentiality may also be broken if the information could help save your life in a life-threatening emergency. Information may also be shared with medical providers who are concurrently providing medical treatment for you to promote coordination of care and the benefit to you of shared knowledge.

For your protection, digital communication through unsecured means is kept to a minimum. We utilize the OnPatient portal which is a secure, fully encrypted platform that will allow you to send/receive direct messages, access your health record, and schedule appointments. Please use the OnPatient portal to ask any clinical questions rather than email. A registration link for OnPatient will be sent to you once you are scheduled. This is the best way to reach me if you have any questions. If you do not wish to use the OnPatient portal, then please call the office telephone number, but it may take longer to receive a response. In either case, it may take 2-3 business days for a response. Please notify the office if you have any difficulties with accessing the portal.

You should know that sometimes during treatment, symptoms become worse before they become better, though this should subside as the work of treatment progresses. You may be asked to have laboratory work or EKG screens done outside of this office, or I may ask that records and test results from your PCP be sent to me. While you have the right to refuse any therapeutic technique, we must be able to discuss your thoughts and feelings about your treatment. You have the right to withdraw from treatment at any time or to ask to be referred to someone else.

You have the right to be informed of your mental health diagnosis after the mental health assessment is completed, and the purpose of any prescribed medication and their potential side effects. We will discuss risks, benefits, and alternatives. You should understand that some medications require a taper to avoid potentially uncomfortable discontinuation syndrome. Continued prescription of medications requires periodic reviews in the office where I can assess how you are doing and if the medication needs to be, or should be, continued. It is important for you to know that medications do not work for everyone.

Please determine who will be involved in your treatment and initial for each:

Name	Relationship	Phone:	Initial
	Primary care provider (PCP)		
	Therapist		
	Family Member		
	Other:		

My signature below indicates that I have read the above information and am requesting mental health treatment from Michael Zaurov, PMHNP-BC

Signature:_____ Date:_____

Parent/guardian signature (for patients under 18):_____ Date: _____

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Patient Policy Agreement – Please read each section carefully. Sign and date at the bottom.
These policies as well as our Privacy policy can also be found on our website - http://www.zaurovpsychiatry.com

1. Services are provided with the understanding that you (not an insurance company) are ultimately responsible for the cost of the services that you are purchasing. Insurance plans vary and not all services may be covered. You are responsible for knowing what services are covered by your particular plan, please check with your plan by calling the number on the back of your card before your appointment. If your need prior authorization for services, this must be completed before you are scheduled.

2. If your insurance does not pay your claim it will be your responsibility to contact them to resolve any issues of coverage or coordination of co-coverage. If you have a change in your insurance, it is your responsibility to notify the office as soon as possible to ensure that the correct company is being billed and that your account does not become past due.

3. The person signing below is the account guarantor and is accepting responsibility to pay for services rendered. This includes those provided to a child - regardless of custodial or legal agreements between parents.

4. Payment for deductibles, co-pays, uncovered services, or any balance due on your account are to be paid at the time of your – or your child's – appointment. Please come, or send your child, prepared to do so. If you are not in a financial position to pay at the time of the appointment, we will be happy to reschedule the appointment for a more convenient time.

5. Accounts with unpaid balances over 90 days past the date of service will be given to an outside collection agency to bill and collect. An additional fee will be added to cover the expenses involved to do so. Your insurance will not pay for these additional charges.

6. If 12 months has passed since you were last seen, you will no longer be considered an established patient with us due to you not following up within the agreed upon amount of time.

7. Prescriptions will be written with enough refills to last until your next appointment. We recommend scheduling your next appointment at the end of each session so that we can be sure you are following your treatment plan and also do not run out of medication. My strict policies primarily reflect my concern for my clients' well-being. Self-assessment of psychiatric symptoms can be difficult and requires quite a bit of practice and feedback, especially early in treatment.

9. **Medication refills are done during the appointment time only.** If something unexpected occurs, please have your pharmacy fax a refill request. Do not email or call about refills. Please allow up to 5 business days for the refill to be approved, if appropriate, and schedule an appointment as soon as possible.

10. Controlled substances such as benzodiazepines and stimulants are tightly regulated by the DEA. These medications can be very useful when indicated, but require more monitoring and must be part of a comprehensive treatment plan. If you do not adhere to the agreed upon treatment plan, then I will be unable to continue to provide care to you. There will be no early refills of controlled substances for any reason.

Patient name:_____ Date _____

Patient/Guarantor signature & relationship _____ Date _____

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Initial visit health history form

Patient's name: _____ **Date of birth:** _____ **Date completed:**_____

In a few sentences, please tell me what is bothering you and how long this problem has been going on:

_____

_____

_____

_____

_____

Was there a recent change or situation that convinced you to make this appointment?

_____

_____

Have you ever been treated before by a mental health specialist (therapist, nurse practitioner, psychiatrist, psychologist)?
If so, please list their name and city/state.

_____

_____

_____

_____

_____

Are you seeing any of these professionals currently? Which ones?

_____

_____

Is it okay if I contact any of these people to obtain records? _____

Have you ever considered or attempted suicide? If so when and how? _____

_____

_____

_____

Been hospitalized for mental health reasons? If so, when, where, and why? _____

_____

_____

_____

Had violent behavior toward another person? Please describe circumstances: _____

_____

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Email: info@transcultural-care.com

TELEPSYCHIATRY INFORMED CONSENT

Patient Name: _____

Location of Patient: _____ Date of Birth _____

Introduction:

Telepsychiatry is the form of telemedicine that allows patients to access psychiatric care using audio-video interface such as videoconferencing.

Electronic systems used will incorporate network and software security protocols to protect confidentiality of patient identification. Imaging data and other protected health information will be protected through measures that safeguard data and ensure the integrity against intentional or unintentional corruption.

Expected Benefits:

1. Improved access to psychiatric care by allowing the patient to remain in the home or office and in a geographical location that serves to be in the patient's best interest to remain due to restrictions in travel.
2. More efficient psychiatric evaluation and management.
3. Obtaining the expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are risk associated with telepsychiatry. These risks include but are not limited to:

In rare case, information transmitted may not be sufficient due to poor resolution to allow for appropriate medical decision making by the telepsychiatrist and client.'

Delays in medical evaluation and treatment could occur due to failure of equipment.

In some cases, there may be a lack of access to complete medical records, resulting in adverse drug reactions or allergic reactions as well as other judgmental errors.

Alternative Options:

There are available appointments to have face-to-face encounter visits in an office setting at the physical location of Transcultural Care and when consent is obtained for telepsychiatry, the client is agreeing to obtain telepsychiatric services.

Please initial you have read this page regarding benefits, risks, and alternative options: _____

Telepsychiatric Policies

Transcultural Care: Telepsychiatry Protocol

1. Telepsychiatry cannot provide any provision of medical or psychiatric emergencies. In the case of emergency, patients are encouraged to seek local help or call 911.

2. Patients who receive telepsychiatric services must be seen in person at least once a year.

3. New Patient consultations are done in person and telepsychiatric encounters are for follow up appointments

4. Guidelines generally considered standard for keeping medical records, release of information, and patient confidentially will be applied to telepsychiatry as well.

5. No recording of session is allowed in any circumstances. Patients need to notify the psychiatric provider if another person is present in the session.

6. After initial evaluation or anytime during treatment the psychiatric provider may recommend local psychiatric services, if patients need are judged to be not met through telepsychiatry or if other clinical grounds exist. Every effort will be made to provide local referrals.

7. Medication fills and refills can only be made after the session and is subjected and limited to local pharmacy's guidelines, limitations, and policies. Prescribing controlled medications will have higher level of scrutiny and will be solely at the discretion of the telepsychiatrist based on clinical needs.

8. No shows and late cancellations of less than 24 hours of appointment time will be charged as the same rate as regular in-office appointments.

9. All payments will be made before the sessions.

I agree with the policies outlined above

Patient's Name: _____

Patient's Signature: _____

Transcultural Care: Telepsychiatry Protocol

By signing this form, I understand the following:

1. I understand the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of tele-psychiatry which identified me will be disclosed to researcher and other entities about my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of tele-psychiatry in the course of my care at any time, without affecting my rate and future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telepsychiatry interaction, and may receive copies of this information for reasonable fee.
4. I understand that a variety of alternative methods of psychiatric care may be available to me, and I may choose one or more of these at any time.
5. I understand that is is my duty to inform my psychiatric provider of any other healthcare providers in my medical/psychiatric care.
6. I understand that I may expect anticipated benefits from the use of telepsychiatry in my care, but then the results can be guaranteed or assured.

Patient Consent to the Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my psychiatric provider or such assistance of may be designated, and all of my questions have been answered to my satisfaction. I hereby giving informed consent for the use of telepsychiatry and my medical use.

I hereby authorize _____ to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient: _____ *Date* _____

If Authorized Signer: _____ *Date* _____

Witness: _____ *Date* _____