PATHWAYS MEDICAL SERVICES, P.L.L.C.
ARSHI T. HAQUE, M.D.
Adolescent & Adult Psychiatry
7150 Preston Road, Suite 100
Plano, TX 75024

REGISTRATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____

Male __ Female __

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security #: _____

Driver's License #: _____ State: _____

Home Phone: _____ Cell Phone: _____

Marital Status: _____ Spouse's Name: _____ Spouse's Date of Birth: _____

Patient's Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip Code: ____

Occupation: _____

_____

Pharmacy **Address** **Phone/Fax #**

Do you have a:

1. DNR (**D**o **N**ot **R**esuscitate) Document? Yes __ No __ If yes, where is it on file? _____
2. Living Will? Yes __ No __ If yes, where is it on file? _____

Treatment and Release of Medical Information: I hereby consent and authorize Pathways Medical Services, P.L.L.C. to treat and/or release any medical information in connection with the services rendered for determination of benefits or collection of said benefits from my health insurance carrier. I understand if my insurance does not pay due to incorrect or lack of information I have given on this form or coverage is denied, I will be responsible for any and all amounts due.

_____

Printed Name of Patient or Legal Guardian

_____ _____

Signature of Patient or Legal Guardian **Date**

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Primary Insurance Company: _____

Policy/Member ID # **Group #**

Insured and Relationship to Patient **Insured's Employer**

Insured's Social Security # **Insured's Date of Birth**

Secondary Insurance Company: _____

Policy/Member ID # **Group #**

Insured **Insured's Employer**

Insured's Social Security # **Insured's Date of Birth**

Policy/Member ID # **Group #**

Do you have any other insurance not listed above? Yes ___ No ___

If yes, please provide us with additional insurance information.

In case of emergency notify: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____Cell Phone: _____

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FINANCIAL POLICY AGREEMENT

Please read and sign this Financial Policy Agreement prior to seeing the doctor. If you have any questions about our payment policies, do not hesitate to discuss your concerns with the office manager.

In order for us to provide proper handling of your insurance claims, we ask that you keep us informed of any changes in insurance coverage. If we do not have all the correct insurance information, this may result in you being billed for all unpaid claims.

We will assist you obtaining reimbursement for the services we provide but it is YOUR responsibility to understand your healthcare network, which physicians and healthcare facilities you may use.

Not all services are covered benefits in all contracts. Those not covered will be your responsibility. Please check with your insurance provider.

All co-payments, co-insurance and deductibles are due and collected prior to seeing the doctor. **If you are not prepared to pay, your appointment will be rescheduled.**

We accept payment by cash, Visa, MasterCard, Discover, and American Express.
WE DO NOT ACCEPT PERSONAL CHECKS.

A $50.00 fee will be applied for **NO SHOW** or **last-minute cancellations**. We respect your time. Please respect the doctor's time.

Thank you for choosing us as your healthcare provider. We appreciate your trust in us and the opportunity to serve you.

Printed Name of Patient or Legal Guardian

Signature of Patient or Legal Guardian **Date**

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TELEPHONE APPOINTMENT REMINDER CONSENT

I, _____
Patient Name

give Dr. Arshi Haque and members of her staff working at the location indicated above, my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at: (check all that apply):

___ Home #: _____ ___ Cell Phone #: _____

Yes, this office may leave: (check all that apply):

___ Voice Mail at Home ___ Cell Phone

___ Messages with people at my home

You may receive a text notification on your cell phone when your medication is sent to the pharmacy.

I understand that I may withdraw, either verbally or in writing, except to the extent that action relies on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

_____
Printed Name of Patient or Legal Guardian

_____ _____
Signature of Patient or Legal Guardian **Date**

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AUTHORIZATION FOR PATHWAYS MEDICAL SERVICES P.L.L.C.
TO RECEIVE OR DISCLOSE MY PRIVATE HEALTH INFORMATION

Patient Name: _____ Previous Name: _____

Date of Birth: _____ Today's Date: _____SSN: _____

(I) My Authorization

Pathway Medical Services may receive or disclose the following health information: (check all that apply)
__ All my health information

__ My health information related to the following treatment or condition: _____

__ All my health information for the dates: _____/_____/_____ Other: _____

Name of Organization **Phone #** **Fax #**

1. _____
2. _____
3. _____
4. _____

Reason for authorization: At my request Other (specify) _____

This authorization ends on: (check one)

__ _____/_____/_____.

__ When the following event occurs: _____

__ When the patient terminates with Pathways Medical Services

(II) My Rights

I understand that I do not have to sign this authorization in order to get health care benefits/treatment/payment/or enrollment. However, I do have to sign an authorization form.

- To take part in research study
- To receive health care when the purpose is to create health information for a third party

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Pathways Medical Services. Based on upon this authorization, I may not be able to revoke this authorization if its purpose was to obtain insurance.

The ways to revoke this authorization are:

1. Fill out a revocation form. The form is available from this office.
2. Write a letter to this office.

_____ _____ _____

Patient Signature/Legal Guardian/POA Date Witness

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(I) I, _____, have received a copy of the HIPAA Policy and guidelines from Pathway Medical Services, P.L.L.C.

_____ _____

Signature of Patient or Legal Guardian/Pryor of Account **Date**

(II) I, _____ authorize the staff at Pathways Medical Services, P.L.L.C. to release any medical information to: (family or friend)

a. _____
b. _____
c. _____
d. _____

_____ _____

Signature of Patient or Legal Guardian/Pryor of Account **Date**

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HIPAA
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT COMPLIANCE

To the Patient, _____ _____
Patient Name **Date**

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

At Pathways Medical Services, we are committed to treating and protecting health information about you responsibly. This notice describes the personal information we collect and how and when we use or disclose that information. The federal Medical records privacy regulation authorizes the use and disclosure of protected health information for treatment payment and healthcare operations. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

USES AND DISCLOSES OF PROTECTED HEALTH INFORMATION may be used on several basis as listed for Treatment Payment and Health Care Operations. Other uses and disclosures of your information may be used for:

- Appointment reminders
- Appointed care giver (family member who sees to your medical needs)
- Emergency situations
- Health care organization
- To avert a serious threat to health or safety
- As appointed by law

UNDERSTANDING YOUR HEALTH INFORMATION & MEDICAL RECORDS. Each time you visit Pathways Medical Services, a record of your visit is made. This record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment
- Means of communications with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you or another payer (your insurance company) will use to verify that services billed were actually provided
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for panning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information and make an informed decision when authoring the disclosure of this information to other individuals.

YOUR RIGHTS AS THE PATIENT under the federal privacy standards are as listed:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning our medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protection health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed and the right to receive a printed copy of this notice

Our responsibilities at Pathways Medical Services are as listed:

- We are required to maintain the privacy of your health information
- Provide you with this notice as to our legal rights and privacy practices with respect to information we collect and maintain about you

- Abide by the terms of this notice
- Notify you if we are unable to agree to the requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit. We will not use or disclose your health information without your authorization except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION for treatment. Your information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. We will use your information for payment. Your health plan may request and receive information regarding dates services provided and the medical condition being treated in order to pay for the service rendered to you. We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of Pathways Medical Services. In some instances, we have contacted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that that we ask them to provide.

Communication with family. Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information.

PLEASE INFORM US WHEN YOU DO NOT WANT A FAMILY MEMBER OR OTHER INDIVIDUAL TO HAVE AUTHORIZATION TO RECEIVE YOUR INFORMATION.

HEALTHCARE OVERSIGHT. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that requires us to do so.

LAW ENFORCEMENT. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

APPOINTMENT REMINDERS. The practice may use your information to remind you about upcoming appointments. If you do not approve of these methods, or you prefer alternative methods, please inform our front office staff.

OTHER USES AND DISCLOSURES. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, PLEASE CONTACT OUR OFFICE.

If you feel your rights have been violated, please contact:

The Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Room 50917, HHH Building
Washington D.C. 20201

To file a complaint, write to:
U.S. Department of Health & Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244