Syed Sajjad Zaidi, M.D.
110 S. Gordon St, Alvin, TX. 77511
Tel: 281-968-7568 Fax:281-968-7569
Medical Records Fax: 832-862-3423

Take your time in reading our introduction.

Thank You for trusting us with your health care needs. We look forward to working with you. We ask that you take this time to fill out our new patient pack.

Please fill out ***all*** the information and return this to the office so we can move forward in scheduling your appointment. You may e-mail, fax or bring the paperwork back to the Office when you are done. If it is after hours, you may drop you pack in the black lock box located on the outside of our building. We will get it the following business day. ***Everything*** must be completed entirely before we can make your appointment. If you have any questions regarding this, please call me at the office.

** Please note: During your initial Psych Evaluation the Doctor will determine what medications, if any, will benefit you. This is ***not*** a guarantee of medication refills. ***All office visits are non-refundable once you have seen the Doctor.***

** **ALL new patient appointments require a $75 deposit.** This will need to be collected when we book your first appointment. This deposit will apply to your account as a credit. If you fail to show up for your initial appointment or cancel/reschedule less than 1 full business day in advance, you will be charged the full fee for the missed appointment.

Dr. Zaidi does not double book appointments. Your appointment time is reserved for you. If you fail to cancel your appointment in advance, Dr. Zaidi is unable to see another patient during that appointment time.

What if I have problems during off hours? If it's not urgent or life-threatening, please leave a message and we will get back to you when we return to the office. If you have an urgent or life-threatening situation that arises during or outside of our normal business hours, please call 911.

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Patient Demographics

Who may we thank for referring you to Focus Psychiatry?			Date:
Full Name	DOB	Age	☐ Male ☐ Female
Address			
City	State	Zip Code	
Home Telephone ☐ Primary Contact	Work Telephone ☐Primary Contact	Mobile ☐Primary Contact	
Social Security Number	Email Address		

INSURANCE INFORMATION

1. Primary Insurance Carrier	Group Number	ID Number
Primary Insured	Employer Name	
Business Address		
Employee Social Security Number	Employee Date of Birth	
2. Secondary Insurance Carrier	Group Number	ID Number
Primary Insured	Date of Birth	

Emergency Contact Name	Relationship	Emergency Contact Number
Primary Care Physician	Last Office Visit - Last Labs	PCP Phone Number

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CREDIT CARD AUTHORIZATION FORM

In adherence to our clinic policy, we require each patient to keep a credit card authorization form on file in the event that you cannot or do not pay fees that are outstanding or remain as part of your visit or as it pertains to any late/no show fees. In this event, we reserve the right to authorize your credit card. Your signature below indicates your agreement and consent to charge your credit card for any outstanding charges for any service fees which may include late appointments, **no shows/cancellations within 24 hours of your appointment**, outstanding balances and other fees as outlined in clinic policies and procedures.

*** New patient appointments require a $75 deposit to secure the appointment. Without the deposit, you can not make a new patient appointment.**

I, _____ (print name as it appears on the credit card), authorize Focus Psychiatry, to submit any charges for professional services that are rendered to _____ (print full legal name of patient receiving services) to my credit card. This authorization applies to all legitimate charges for any individual whom I have accepted financial responsibility and includes all current and future outstanding charges.

Name on Credit Card: _____

Type of Credit Card: ☐Visa ☐MasterCard ☐American Express ☐Discover ☐ Other

Card Number : _____ - _____ - _____ - _____

Expiration Date: _____/_____

Card Verification Data:_____ (3 digits on back of credit card for most; American Express may be in front of card)

Zip Code Applicable to Credit Card: _____

Full legal name of patient authorized for use: _____

Signature of Cardholder: _____ Date: _____

FOCUS PSYCHIATRY

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Please initial each line and sign at the bottom of this form.

1. _____ **FEMALE PATIENTS-** If taking medications I agree to notify my provider in the event that I am planning to become pregnant, or I become pregnant so that I may discuss the risk/benefits of medication.

2. _____ **ALCOHOL/ILLICIT'S-** It is recommended not to use alcohol/drugs or herbal supplements in combination with prescription psychiatric medication and I agree to notify my provider if this is a concern. **We reserve the right to do a random urine drug test, at any time, at the pt's expense.** A positive drug test for Illicit's, more than once, can be grounds for termination of services.

3. _____ **MEDICATION REFILLS-** Medication is prescribed to last until your next appointment. If you require medication refills you will need to be seen in office. **We *reserve* the right to deny medication refill when *appts are not* kept.** . If your meds make you drowsy or slows your reaction time, Do Not Drive or operate machinery. Notify Dr. Zaidi if there are any significant changes in your mental health and/or medical condition or if another provider changes your medications. With some exceptions, refills are not permitted for medications prescribed under this system.

4. _____ **FOLLOW UP APPOINTMENTS-** Follow ups are scheduled for 15 minutes. In order that you receive your entire session, please be prompt for your appointment. For sessions that extend past the 15 min, an additional charge may be applied.

5. _____ **ADDITIONAL CHARGES-** We charge for the completion of paperwork (anything that requires a Doctor signature) on letters, forms, work release etc. Fees will be determined by your provider. **Fees are due at the time forms are completed.**

6. _____ **CONFIDENTIALITY-** All information is guarded by strict confidentiality . We require your written consent in order to release/obtain information. Please see our consent to release information form.

7. _____ **MANAGED CARE PLANS-** This practice has contracted with several managed care plans and will be handled according to our agreement with them. All co-payments must be paid at time of service. It is your responsibility to be aware of coverage variables, such as preventive health care, deductibles, etc, and to pay for services not covered by your insurance company. Following notification from the insurance company, any denied amounts would be due immediately, upon being notified by our office.

8. _____ **CANCELLATIONS-** ***Cancellations must be made 24 HOURS before your session.*** Your session is reserved for you and you will be charged a **$75 no show/cancellation fee** for late cancellations or missed appointments.

9. _____ **INCASE OF EMERGENCY-** If you feel you are at risk of hurting yourself or others, Call 911 or proceed to your nearest emergency room. There is no on call answering services after business hours. In the event you are hospitalized please call the office during business hours to notify us.

10. _____ **BILLING INQUIRY-** We will be pleased to help you with billing questions. Our billing office can be reached at 281-259-7260.

11. _____ **LABORATORY/ DIAGNOSTIC TESTING-** This office is not responsible for obtaining authorization for these tests. Please contact your insurance company for a listing of preferred providers.

12. _____ **INSURANCE INFORMATION-** ***Please provide any change in your insurance to our staff 24-48 hrs before your appointment.*** Submit new info by fax, e-mail or calling our office. New insurance without verification will result in a co-pay of the allowable amount designated by your insurance company.

I agree that I have read and understand the above policies and agree to the terms regarding payment responsibilities.

Patient's Name (Print): _____

Signature: _____ Date: _____

DISCHARGE POLICY

There are times that Focus Psychiatry has to make a decision to end the patient/provider relationship. The following are situations in which termination is appropriate and acceptable ONLY by the provider.

Termination: A good relationship between a physician and his or her patient is essential for quality medical care. There are times when this relationship is no longer effective and the physician finds it necessary to ask the patient to select another physician. The following are some of the situations that would make this necessary:

1. Treatment noncompliance: The patient does not or will not follow the treatment plan and/or the guardian of the patient will not guide the patient to follow the treatment plan.

2. Follow-Up noncompliance: The patient and/or the guardian of the patient cancels and/or does not show-up for the follow-up appointments as recommended by the provider. Multiple no shows are automatic grounds for termination.

3. Verbal Abuse: The patient and/or the guardian of the patient and/or family member of the patient is rude and uses improper language with the office staff, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well being of office staff and others around.

4. Office Policy noncompliance: Any and or all violations of the policy and guidelines.

5. Nonpayment: The patient owes and makes no effort to make payment arrangements.

6. Improper use of medication: Receiving same medication from multiple doctors, altering scripts, abusing medication, sharing/trading/selling medication, not informing Focus Psychiatry about taking other controlled medications-such as pain medications.

7. Disruptive Behavior: Lack of supervision of minors (under the age of 18), loud and unruly behavior causing disruption, disturbance to others and clinic routine, standing in the hallway and infringing on the privacy of patients

8. Receiving controlled medications from multiple providers.

Patient's Name (Print): _____

Signature or Legal Guardian Signature: _____ Date: _____

FOCUS PSYCHIATRY

Syed Sajjad Zaidi, M.D.
110 S. Gordon St. Alvin, Texas 77511
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Authorization to Disclose to Primary Care Physician (PCP)

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Please check one of the following:

[ ] I do not have an existing primary care physician. **(if checked please skip the boxes below and sign and date the form)**

[ ] I, do have a PCP: (If checked, please fill in the box below)

PCP Name:_____

PCP Phone:_____ PCP Fax:_____

PCP Address:_____

Patient Name: _____ DOB: _____

[ ] **AUTHORIZE** [ ] **DO NOT AUTHORIZE** Dr. Zaidi at Focus Psychiatry

to disclose any applicable behavioral health information (including diagnosis, treatment plan, prognosis and medication(s) to the PCP indicated in the box above for the purpose of collaboration of care.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six(6) months from the date of signature, unless another date is specified.

I have read and understand the above information and give my consent.

Patient Signature:_____Date:_____

Personal Representative Signature:_____

Relationship to Patient (required):_____

FOCUS PSYCHIATRY

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Financial Policy

Payment Policies:

- Payment for services are due at the time of service, no exceptions. We accept Cash, Check, American Express, Visa, MasterCard, and Discover. ***An office visit is not a guarantee of medication refills. Office visits are non-refundable.*** There will be a **$25 fee** for each returned check.

New Patient's:

- Please be aware that a deposit of $75.00 must be made when scheduling your new patient appointment. This will apply as a credit on your account.

Appointment Cancellations:

- There is no penalty for appointment cancellations made at least 24 hours in advance.
- Cancellations with less than 24 hours notice of your scheduled appointment will be charged a $75 fee, due in full before the next appointment.
- The first no call, no show will be charged a $75 fee. If there are any subsequent no call no shows we reserve the right to *terminate services*. If you have an emergency and are unable to keep your appointment please call the office ASAP. We may waive the fee depending on the circumstances. The fee will not be waived more than once.
- Any outstanding balances may be sent out to collections if not paid in full.
- Please note that reminder calls/texts and emails are a courtesy. You are responsible for your appointment whether your reminder was received or not.

Medical Records:

- Copies of medical records may be obtained upon request. Please allow 10 days for processing. A fee of $20 is charged for the first 20 pages, and then $0.50 for each additional page. This does not include records that are directly transmitted to other sources, such as another medical office, school, or therapist.

I, _____, acknowledge that I have read and the payment
(print patient or guardian name)
and cancellation policies.

Signature: _____ Date:_____

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Medical Information Release Form

(HIPAA Release Form)

Name:_____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims inform. This information may be released to:

[ ] Spouse_____ Phone Number_____

[ ] Other _____ Phone Number_____

[ ] Other_____ Phone Number_____

[ ] Information is ***not*** to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [ ]my home [ ] my work [ ] my cell Number: _____

If *unable* to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between *(time)*_____

Signature/Guardian Signature: _____ _____ Date: _____

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Consent for Evaluation and Treatment

Name of Patient: _____ Date:_____

Name of Parent or Guardian (if patient is a minor):

_____

I acknowledge that I am voluntarily seeking medical evaluation by Syed Sajjad Zaidi, M.D. I understand that as a part of that process, I may be recommended to receive diagnostic testing, psychological testing, psychotherapy and/or medication management. I understand that I have the ability to decline the aforementioned services at anytime, but this may affect my treatment process and outcome.

The following types of medications are commonly prescribed to treat psychiatric conditions:

- Antidepressants
- Antipsychotics
- Anxiolytics
- Stimulants
- Mood Stabilizers

I also understand that refusal to comply with Dr. Zaidi's recommendations could result in grounds for termination of the patient – physician relationship. I also understand that I have the right to terminate the relationship at anytime.

Patient signature: _____ Date: _____

Guardian Signature and Relationship: _____

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Notice of Electronic Disclosure of Protected Health information

If Focus Psychiatry obtains or creates information about your health, they are required by law to protect the privacy of your information. Protected health information (PHI) includes any information that relates to:

- Your past present, or future physical or mental health or condition;
- Health care provided to you; and
- Past, present, or future payment for your health care

Focus Psychiatry may not disclose your (PHI) electronically without your authorization unless allowed by law. For example, we may share your (PHI) through approved, secure electronic methods for the purpose of treatment, payment for health care services, or health care operations such as a case management or care coordination. Focus Psychiatry may also need to share your (PHI) electronically for public health purposes such as preventing and controlling the spread of infectious diseases or for certain disaster relief efforts. For a complete list of reasons that Focus Psychiatry is allowed by law to share your (PHI) please refer to Focus Psychiatry Privacy Notice. If you believe that Focus Psychiatry has violated the obligations described in this notice, you have the right to file a complaint by mail with us, Attn: Privacy Officer, 110 S. GORDON ST, ALVIN, 77511, OR by calling 281-968-7568.

Printed Patient Name:_____ Date:_____

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110 S. Gordon St, Alvin, TX. 77511
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ACKNOWLEGMENT OF RECEIPT OF CLINIC POLICIES AND PROCEDURES

As a healthcare provider, we are required to make you aware of Focus Psychiatry clinic policies and procedures. Please review our current policies and procedures and fill out an Acknowledgement of Receipt of Clinic Policies and Procedures after review. By signing, you consent to agreement to your rights as a patient and understand that these rights may be limited by certain legal policies implemented to protect your safety. By signing, you also agree to all the specified clinic rules and procedures and acknowledge that failure to follow such guidelines on your behalf as a patient may result in termination of your treatment. All Policies and Procedures are subject to change. These changes will be reflected in the Clinic Policies and Procedures. By signing, you acknowledge that you have received and reviewed all the applicable policies and acknowledge your understanding and agreement with Focus Psychiatry clinic policies and procedures:

Patient Signature: _____ Date: _____

Printed Name: _____

Authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

FOCUS PSYCHIATRY

Syed Sajjad Zaidi, M.D.
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Ph: 281-968-7568 Fax: 281-968-7569

Medical History - 4 Pages

Date: _____/_____/_____ Birth Date: _____/_____/_____ Age:_____ Sex: □ F □ M

Patient Name: _____

Primary Care Physician: _____ Last Visit: _____ Last Labs: _____

Preferred Pharmacy: _____ Ph: _____

Briefly list the reason you are here:

Please check all stressors you are currently experiencing:
□ Sadness □ Insomnia □ Panic attacks □ Obsessions/compulsions □ Hopelessness □ Guilt □Grief/loss □ Racing thoughts
□Anxiety □Fatigue □ Withdrawal/decrease socialization □Decrease interest levels □ Irritability/easy anger □ Aggression
□ Behavioral problems □ Impulsivity □ Uncontrolled fear/phobia □ Nightmares □Recollection of Trauma □ Worthlessness
□ Chronic pain issues □ General overwhelming stress □ Thoughts of hurting self □Active plan to hurt myself □ Hallucinations (hearing voices/seeing things) □ Difficulty with work/school/family □ Difficulty motivating myself to do basic responsibilities
□ Mania (decrease sleep accompanied by very high energy or agitation, impulsivity, increase in goals, drive to do activity)
□ Rapid weight loss/weight gain □ Eating disorder □ Memory impairment □ Personality changes □ Development disorder □ Economic/Financial □ Education/School □ Family Conflict □ Grief/Loss □ Legal Problems □ Medical Illness Work □ Living Situation □ Social Environment □ Substance Abuse □ Marital Conflict □ Family Disruption due to divorce or separation □ Personal Injury □ Relationship □Environmental change

Psychiatric History

Have you ever seen a specialist/psychiatrist? □ Yes □ No Is yes, please fill below:

Name of Physician/Clinic	Duration of Treatment Month/Year	City/ State	Reason for treatment

Have you ever seen a primary care doctor for mood issues? □ Yes □ No
If so, please explain when and for what reason?

Have you ever been hospitalized in a psychiatric facility? □ Yes □ No If so please fill below:

Name of Hospital	Month/Year	City/State	Reason for treatment

Have you ever presented to emergency room for any anxiety/mood relates issues? ☐ Yes ☐ No
Is yes, please explain below:

_____

What diagnoses have you been treated for:
☐ Major depression ☐ General anxiety disorder ☐ Obsessive compulsive disorder ☐ Bipolar disorder ☐ Schizophrenia ☐ Autism
☐ Schizoaffective disorder ☐ Eating disorder ☐ Personality disorder ☐ ADHD/ADD ☐ Post-traumatic stress disorder
☐ Other: _____
Please check any that apply to your psychiatric history:
History of suicidal ideation: ☐ Yes ☐ No
Suicide attempts: ☐ Yes ☐ No
If above checked please specify: _____(number of suicide in lifetime)
Any hospitalization as a result? ☐ Yes ☐ No
History of aggressive/threatening behavior: ☐ Yes ☐ No
History of self-injury/cutting: ☐ Yes ☐ No

Any past history of trauma:
☐ Childhood physical abuse ☐ Childhood emotional/verbal abuse ☐ Childhood sexual abuse ☐ Childhood exposure to domestic violence
☐ Combat Trauma ☐ Witness to death of loved one ☐ Survivor of suicide ☐ Exposure to potentially deadly/deadly accident
☐ Exposure to fire ☐ Exposure to natural disaster ☐ Partner physical/emotional/verbal abuse ☐ Stranger Rape/Assault
☐ Rape/Assault by family member ☐ Exposure to war ☐ Early parental loss ☐ Neglect in childhood ☐ Forced prostitution
☐ Other: _____

If you checked any of above please specify briefly the circumstance:

_____

Past Medical History

Do you now or have you ever had:

☐ Diabetes
☐ High blood pressure
☐ High Cholesterol
☐ Hypothyroidism
☐ Goiter
☐ Cancer (type) _____
☐ Leukemia
☐ Psoriasis
☐ Angina
☐ Heart problems
☐ Heart murmur
☐ Pneumonia
☐ Pulmonary embolism
☐ Asthma
☐ Emphysema
☐ Stroke
☐ Epilepsy (seizures)
☐ Cataracts
☐ Kidney disease
☐ Kidney stones
☐ Crohn's disease
☐ Colitis
☐ Anemia
☐ Jaundice
☐ Hepatitis
☐ Stomach or peptic ulcer
☐ Rheumatic fever
☐ Tuberculosis
☐ HIV/AIDS

Other medical conditions (please list): _____

Have you had any surgeries in the past (please list procedure and date):

_____ _____
_____ _____
_____ _____

Family Medical History

Problem	Mother	Father	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Sibling(s)	Children
Depression								
OCD								
Anger/Aggression								
Bipolar Disorder								
Schizophrenia								
Completed Suicide								
Attempted Suicide								
Drug Abuse								
Dementia								
Autism/Delay Development								
Psychiatric Treatment								
Psychiatric Hospitalization								

Any of your family member have the below medical conditions:

If so, please check and specify who below:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS

Please specify which family member and any other conditions they may have that are not listed above:

_____

Substance Abuse History

Are you a smoker? ☐ Yes ☐ No
If yes, how many packs do you smoke? _____ Any attempts to quit: _____
If you quit using, how long? _____
Do you consume alcohol? ☐ Yes ☐ No
How often do you drink? ☐ Weekly _____/wk ☐ Monthly _____/month ☐ Rarely _____
☐ Quit drinking _____(specify last usage)
Specify amount you drink in each setting: _____
Do you have a history of Substance Abuse**?** ☐ Yes ☐ No
Have you ever attended rehab? ☐ Yes ☐ No
If yes, Please state when and for treatment of what: _____

Other substances used:

Substance	Quantity	Used Frequency of Use	Quit (Y/N)	Last Used
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you experienced any of the following as a result of your drug or alcohol use?
☐ Arrests ☐ Consuming more than intended ☐ Blackouts ☐ DUI ☐ Employment Issues ☐ Family/Marital Conflict ☐ Feeling guilty
☐ Financial problems ☐ Fighting ☐ Health Problems ☐ Increased Tolerance ☐ Increased tolerance ☐ Unintentional Overdose
☐ Physical Health Problems ☐ Seizures ☐ Withdrawal Symptoms

List any other consequences not listed above: _____

Current Medications

Name of Medication	Dose (include strength & quantity per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Drug allergies: ☐ No ☐ Yes If yes, please List: _____

What reaction did you have: _____

Have you tried any psychiatric medications for mood/anxiety/sleep before? ☐ No ☐ Yes

If so, briefly list some you recall: _____
Was there one or more medications (including combinations) that were particularly beneficial to you? □ No □ Yes
If yes, please list: _____

If you were on medications for mood/sleep/anxiety:
What was the last medication you were given that you recall? _____
If you discontinued what was the reason? _____

Social History

If patient is a child/adolescent:
Patient lives with/raised by : _____Any siblings: _____
Are parents divorced? □ No □ Yes If yes specify arrangement: _____
Any step-parents: □ No □ Yes Specify: _____

If patient is an adult:
Relationship Status: □ Single □ Married □ Divorced □ Widowed □ Life/serious partner
Are you happy in your relationship: □ No □ Yes
Describe your relationship satisfaction: □ Not applicable □ Very Satisfied □ Somewhat satisfied □ Dissatisfied.

Any children: □ No □ Yes

Specify Name/Sex/Age of children below:

Name	Son/Daughter	Biologic/Step/Adopted	Age

Please describe the following:
Sleep: _____ hrs/night □ Difficulty falling asleep □ Waking up in middle of night □ Nightmares □ Restless sleep □ Daytime Fatigue
Appetite: □ Same as before □ Decreased □ Increased □ Dieting
Any weight changes: _____ Energy levels: _____
Are you functioning as you did before: □ Yes □ No

Education History:
□ Currently in school: _____(specify)
□ Less than a high school education □ Graduated from high school
□ GED Obtained-Specify highest grade completed: _____
□ Associates Degree □ College Degree □ Some College □ Professional Degree □ Technical Degree □ Master's Degree

Employment status:
□ Full-time □ Part-time □ Unemployed □ Retired □ Disabled □ Homemaker

Occupation: _____ Employer: _____
How long have you had this job: _____

Residential Status:
□ Own A home □ Rent □ Live w/parents □ Foster Care □ Homeless □ Nursing Home Facility □ Live w/roommate(s)

Social Supportive Network:
□ Supportive Family □ Friends □ Religious Congregation □ Co-workers □ Internet-based □ Social Services □ Sponsor

Any other pertinent information that you feel is important to your treatment:
_____
_____
_____
_____