Dr. Babur Bhatti MD

Your Perfect Road to Recovery

Please sign all highlighted areas

Patient Intake Form (Virtual Visits)

PATIENT INFORMATION	**Please type in this column**
Date:	
Name:	
Date of Birth:	
Home Phone:	
Cell Phone:	
Email:	
Gender:	
Social Security Number:	
Address:	
Marital Status:	
Employment Status:	
Ethnicity:	
Emergency Contact	
Emergency Contact Name & Relationship:	
Emergency Contact Phone Number:	
Who may we thank for referring you?	
INSURANCE INFORMATION	
Insured's Relation to Patient:	
Name of Insured:	
Insured's address:	
Insured's Date of Birth:	
Insured's Social Security Number:	
Insured's Phone Number:	
Insurance Name:	
Subscriber Number:	
Group Number:	
Insurance Address	
Signature: (Type Initials)	

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ADMINISTRATIVE AGREEMENT
NOTICE OF PRIVACY PRACTICE

Patient Name (print): _____

I acknowledge that I have reviewed the IBHS Privacy practice Form which is available at the front desk or by requesting via E-Mail
veronicabk@ibhspsych.com.

Patient's Initials (Responsible Party if Minor): _____

PRESCRIPTION POLICY

I acknowledge the IBHS providers do not perform telephone refills and that I must be present for a face to face visit in order to obtain a medication refill. I understand that it is fully my responsibility to schedule a follow-up appointment with my provider prior to running out f medication. I understand that auto-refills requested by my pharmacy will be denied and that my lost prescription for a controlled substance will not be replaced without a police report. I understand IBHS providers do not prescribe narcotic pain medications such as Lortab, Oxycontin, Roxicodone, Vicodin, and Morphine. To replace lost prescriptions, I acknowledge a charge of 10$ each.

Patient's Initials (Responsible Party if Minor): _____

AUTHORISATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

I hereby authorize IBHS to release or receive any information necessary or *process insurance claims*. In case I would like to release my medical information to another medical provider, or to a family member or other designated person, I understand that this process involves the completion of a separate form entitled' **Authorization for Release of Medical Information**' which I have access at any time by requesting via email to **veronicabk@ibhspsych.com.**

Patient's Initials (Responsible Party if Minor): _____

MESSAGES/EMERGENCIES/AFTER HOUR CALLS

I understand that if I have an emergency, such as suicidal thoughts, I should call 911 or go to the nearest ER. For urgent clinical issues such as severe side effects from a medication, I should present to ER. I understand that I should leave a voicemail message that will be checked the following business day. I understand that I should use phone communication and NOT email regarding any clinical concerns, appointments or medications.

Patient's Initials (Responsible Party if Minor): _____

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CONTINUITY OF CARE & FOLLOW-UP TREATMENT POLICY

To ensure adequate medical oversight and practice in accordance with the accepted standard of care, I agree to be seen for all follow-up appointments by my provider every 3 months depending on your clinical presentation. I understand that if I have not been seen in 4 months my chart will be closed and will require a new patient appointment in order to be re-opened. I understand if the above policies are not adhered to, IBHS will not be able to provide the care I need and I may be discharged from the practice.

Patient's Initials (Responsible Party if Minor):

FINANCIAL AGREEMENT

I understand , agree and accept the following terms,

- All payments and/or co-payments are payable on the day of service, prior to the appointment
- I am directly and fully responsible for charges not covered by my insurance company, such as copayments, deductibles and balances for non-covered services. Such payment is not contingent on any settlement, judgment, or insurance payment by which I might recover said fee. In case my insurance fails to pay my balance in full or there is no payment made within 60days, it is my responsibility to pay for services rendered. Failure on my part to notify IBHS of any changes to my insurance provider or policy prior to my next appointment, I will be responsible for any charges not covered by my insurance company.
- Failure on my part to make timely payments on my account means I am responsible for any and all reasonable costs of collection; including filing fees as well as attorney fees. I understand that any outstanding balance of 90days with no attempt to pay will be turned over to collections. In case my account is turned over to collections, I must contact the agency for payments.. I understand that it will be up to the discretion of the office to re-accept a patient back to IBHS once their account has been turned over to collections. I acknowledge and agree the collection agency affiliated with IBHS may contact me by telephone on numbers associated with my account. I further agree that I will notify the collection agency of my ownership of that telephone contact information.
- In case I use a credit card for payment and I am not the card holder, I will supply a notarized statement from the card holder.
- There will be a 35$ charge on all returned checks

Patient's Initials (Responsible Party if Minor):

NON COVERED SERVICES AGREEMENT

I understand that IBHS will make every effort to ensure my treatment is authorized by my insurance company. However, in the event that my insurance refuses, for any reason to authorize services as medically necessary, I understand, agree and accept that I will be responsible for all charges associated with my care.

Patient's Initials (Responsible Party if Minor):

Please sign all highlighted areas

MEDICAL FORMS & MEDICAL RECORDS FEES

I understand that IBHS is more than delighted to provide a letter from my provider, complete medical forms or provide medical records on my behalf. However, I understand, agree and accept that there will be a fee for these services due at the time of request which is not billable to my insurance for which I am solely responsible. I understand that these fees are compliant with Florida Statutes and these services may require up to 5 business days to complete.
-FMLA/Medical Leave/Disability -150 for initial paperwork and 100$ for every subsequent paperwork there after
-Jury Duty: $50
-Medical records: $1 per page up to 25 pages and 0.25 cents per page thereafter.
-Narrative Report: $100

Patient's Initials (Responsible Party if Minor):

APPOINTMENT CANCELLATION/NO SHOW FEES

I understand that I must notify IBHS by telephone (office line only, voicemail is acceptable) of an appointment cancellation at least 24hours prior to the scheduled appointment time and only on business days. Any cancellations on weekends will be considered No Show and a 50$ No Show fee will be incurred. Initial appointments require a non-refundable 50$ retainer fee collected at the time appointment is set up. This fee will count towards deductible/copay if visit is honored. In the case the appnt is cancelled on a non-business day or less than 24hours to the visit, the 50$ is nonrefundable. I understand, agree and accept that I will be charged as below for a late cancellation (within 24hours) or if I do not show to my appointment. I understand that this charge is not billable to my insurance and that I am solely and completely responsible for this payment.

MD Initial Visit - $50
To reschedule a No Show new appnt: $100
MD Follow-up Visit -$50

Patient's Initials (Responsible Party if Minor):

NOTICE OF PRIVACY PRACTICES

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from IBHS . Your health information may include information created and received by IBHS may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information: We may use and disclose health information for the following purposes:

• For Treatment.
We may use health information about you to provide you with medical treatment or services.
We may disclose health information about you to doctors, nurses, technicians, staff or other p For Treatment.
We may use health information about you to provide you with medical treatment or services.
We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

Different personnel in our organization may share information about you and disclose information to people who do not work for IBHS in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work

and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition

• For Payment.
We may use and disclose health information about you so that the treatment and services you receive at IBHS may be billed to and payment may be collected from you, an insurance company or a third party

Patient's Initials (Responsible Party if Minor):

For Health Care Operations
We may use and disclose health information about you in order to IBHS and make sure that you and our other patients receive quality care. We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS
We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

• To Avert a Serious Threat to Health or Safety.
We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

• Required By Law.
We will disclose health information about you when required to do so by federal, state or local law.

• Military, Veterans, National Security and Intelligence.
If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

• Workers' Compensation.
We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

• Public Health Risks.
We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

• Lawsuits and Disputes.
If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

• Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
If you have any questions about this notice, please contact our designated privacy official/contact person at

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(904) 551-9701

Patient's Initials (Responsible Party if Minor):

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

I hereby authorize IBHS to bill my insurance company directly for services rendered. I authorize payment directly to this practice of any insurance benefits otherwise payable to me. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to Integrative Behavioral Health Sciences for which fees are payable.

Patient's Initials (Responsible Party if Minor):

CONSENT TO TREAT

I hereby consent to examination and treatment by provider at **Integrative Behavioral Health Sciences**. I hereby affirm that I am of legal age and otherwise competent to consent to medical treatment; or if not the person signing below represents the parent, legal guardian or person otherwise allowed by law to consent to the examination of the patient and by their signature hereto consents.

Patient's Initials (Responsible Party if Minor):

I hereby attest that I have read and understood the information provided to me regarding IBHS Policies and Procedures and I agree to abide by these terms and conditions. Practice Policies were last updated December 28th, 2019 and are subject to change at the discretion of Integrative Behavioral Health Sciences.

Patient's Initials (Responsible Party if Minor): ___ __ Date: _____

Patient Name (print): _____

Please E-mail forms to Veronicabk@ibhspsych.com