Welcome to Mid Cities Psychiatry!

Mid Cities Psychiatry

In the event of an emergency situation, go to your nearest emergency room or call 911

Patient Intake: Completing the patient intake form is essential and takes approximately 35-40 minutes. Failure to complete this form may prevent us from scheduling your appointment and providing necessary care.

Medications and Refills:

Refill Requests: Submit requests through your pharmacy via fax to 855-295-2686 at least four business days before your medication runs out. Refills are processed only on business days (excluding weekends and holidays).

Controlled Substances: A $25 fee applies for refill requests made between visits for Schedule II substances, as regulated by the Texas Prescription Program.

Lost Prescriptions: A $25 fee and a provider's approval at your next scheduled visit are required for any lost prescription replacements. If no upcoming appointment is scheduled, we will arrange one.

Prior Authorization: Some medications require prior authorization, which may take up to five business days, depending on insurance.

Inactive Patients: Patients not seen within 60 days may need a follow-up visit for refills. Inactivity extends to those not seen or in contact for four months.

Communication:
Our administrative staff handles all appointment requests and will strive to return calls within one business day. For billing inquiries, please speak with our billing staff or Practice Manager.

Termination of Care:
Termination of the physician-patient relationship may occur due to nonadherence to treatment, medication abuse, verbal abuse, violent behavior, distrust, or nonpayment of bills.

Guidelines for Continued Care:

- **Appointments**: You are responsible for attending your scheduled appointments. We send three reminders and adhere to strict scheduling to respect both your time and ours.
- **Medical Records**: Patients have a right to access their medical records under federal law upon the payment of the processing fee; please allow four business days to process requests.
- **Virtual Visits**: Virtual visit sessions are billed at standard office rates.
- **Documentation**: An appointment is necessary for the completion of FMLA/STD/LTD or other forms.
- **Inactive Status**: May be applied after three missed appointments within 90 days. Inactive patients may receive up to one month of prescribed medication while they transition to a new provider.
- **Legal Proceedings**: If legal involvement requires Mid Cities Psychiatry's team members' participation, advance payment at the team member's hourly rate (three-hour minimum) and five business days' notice are required. Failure to comply may result in legal action to oppose the subpoena.

By signing below, you acknowledge and agree to the terms outlined in this form.

I have reviewed and understand Mid Cities Psychiatry's Practice Policy, and I agree to be bound by its terms. I also understand that Mid Cities Psychiatry reserves the right to modify its Practice Policy.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

Payment / Balance / Cancellation / Rescheduling / No-Show Policy

(Your appointment is crucial for us to ensure your well-being and provide the best possible care)

Payment Obligations:

- **Services:** Services may be withheld if copays, co-insurance, deductibles, or outstanding balances are not paid unless payment arrangements are approved.
- **Financial Difficulties:** Contact us immediately to discuss potential payment arrangements.
- **Late Payments:** A $25.00 late fee is applied if a payment under a payment plan is missed. Future appointments may be canceled.
- **Missed Payments:**
  - Full balance clearance is required before scheduling future appointments.
  - Payments must be received within 21 days of a missed payment; otherwise, accounts may be referred to collections, and the physician-patient relationship could be terminated.

Appointment Policies:

- **Cancellations, Rescheduling, and No-Shows:**
  - A fee is charged for cancellations or rescheduling within 24 business hours of an appointment, or for no-shows, as per our RCN Fee Schedule.
  - If you arrive more than 15 minutes late, your appointment will be rescheduled, and a fee will be charged.
  - Fees are non-refundable, but may be discounted or waived in emergencies upon providing proof.
- **Missed Appointments:** Three no-shows within 90 days may result in termination of the physician-patient relationship.

RCN Fee Schedule:

- **40-minute medication management:** $150.00 no-show fee.
- **Psychologists' appointments:** $150.00 per hour no-show fee.
- **Therapist appointments:** $150.00 no-show fee.
- **20-minute medication management:** $75.00 no-show fee.

Credit-Card Information

☐ Credit Card ☐ Debit Card

Name of Card Holder			
Card # (last 4 digits only)	XXXX-XXXX-XXXX-		
Card Expiration Date		Card Security Code	XXX

I, hereby authorize Mid Cities Psychiatry to debit my/our credit card account as per RCN Fee schedule anytime there's a canceled or rescheduled appointment within 24 business hours or in case of a no-show.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

Mid Cities Psychiatry

Registration Form

Demographics

Full Name: _____ Date of Birth: _____ Social Security Number:_____

Height _____Weight_____

Please only fill the information on the following line if you are able to:

Temperature (Fahrenheit)_____ BP_____ Pulse_____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Gender Neutral ☐ Non-Binary ☐ Choose not to disclose

☐ Other: _____

Sexual Orientation: ☐ Asexual ☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Pansexual ☐ Choose not to disclose

☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Would not like to disclose

Race: ☐ American Indian or Alaska Native ☐Asian, Black or African American ☐Native Hawaiian or Other Pacific Islander ☐ White ☐ Other: _____

Reason for visit: _____

Email:_____ Home Phone Number: _____

Cell Phone Number:_____ Work Phone Number:_____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relation to Patient: _____

Emergency Contact's Primary Phone: _____ Alternate Phone Number: _____

Referral Source Name: _____ Preferred Language: _____

Are you Employed? ☐ Yes ☐ Disabled ☐ Retired ☐ Unemployed ***If yes, please answer the questions below about employment, otherwise please skip them.***

Type of Employment: ☐ Full Time ☐ Part Time

Company Name:_____ Occupation Name:_____

Have you served in the military? ☐ Yes ☐ No ***If yes, please answer the questions below about military service, otherwise please skip them.***

Which branch did you serve in? ☐ Army ☐ Guard ☐ Navy ☐ Reserves ☐Marines ☐ Coast Guard ☐ Air Force

How long did you serve?_____

What type of discharge did you receive? ☐ Honorable ☐ Dishonorable

If you answered Honorable:

Were you involved in any combat? ☐ Yes ☐ No ***If yes, please describe Combat experience:*** _____

_____

Are you troubled now by your military experience? ☐ Yes ☐ No ***If Yes, please describe:*** _____

_____

If you answered Dishonorable:

Please explain :_____

_____

Have you completed your education? ☐ Yes ☐ No ***If yes, please answer the questions below about education, otherwise please skip them.***

Highest Schooling: ☐ High School/GED ☐ Associates ☐ Bachelors ☐ Masters

Please provide a copy of an ID to the front desk for them to scan into your chart when you hand them this form.

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

Self-Pay Or Insurance

Are you a self-pay? Yes ☐ | No ☐ <> If YES, please go to the next page, If NO, please continue

Primary Insurance Name _____ must attach primary insurance card

Secondary Insurance Name Yes ☐ | No ☐ _____
If YES, must attach secondary insurance card

Tertiary Insurance Name Yes ☐ | No ☐ _____
If YES, must attach tertiary insurance card

Medicare Patient
As per the policy of this clinic, Medicare patient is <u>required</u> to complete/sign "Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R131" last page of this Registration-Form.

_____ (please initial)

Patient Financial Policy

Overview: We are committed to providing the highest level of care and service. Understanding your financial responsibilities is an essential part of your treatment and care. If you have any questions regarding these policies, please discuss them with our staff.

Payment Policies:

- **Payment Due:** Full payment is required at the time of service unless other arrangements have been made in advance. We accept checks (payable to Mid Cities Psychiatry), cash, debit cards, and credit cards for your convenience.
- **Insurance Coverage:**
  - **In-network Insurance:** We have agreements with many insurers and health plans. We will bill these plans directly, and you are only responsible for the co-payment at the time of service.
  - **Out-of-network Insurance:** If we do not have an agreement with your insurer, we will still send claims on your behalf. Be aware that your share of costs may be higher with non-contracted providers.
  - **Service Coverage:** Not all services may be covered by your insurance. Services deemed "not covered" by your insurance will require full payment by you upon receipt of our statement.
  - **Insurance Claim Processing:** Do not assume your insurance is processing your claim. If no payment notification is received within 30-45 days post-treatment, contact your insurance directly. You are responsible for any services not reimbursed by your insurance.

Responsibilities for Minor Patients:

- Payment for services rendered to minors must be fulfilled by the accompanying adult or the custodial parent/guardian.

Additional Information:

- **Authorization Requests:** If your insurance requires prior authorization or a referral, please notify our staff in advance so we can comply with these requirements.
- **Insurance Delays or Denials:** Engage with your insurer or benefits office promptly if there are delays. You consent to pay directly for services deemed non-medically necessary by your insurer.
- **Non-Sufficient Funds (NSF) fees:** NSF fees $25.00 will be charged for failed transactions for bounced checks or declined ACH payments.

By my signature below, I acknowledge and understand that it is ultimately my responsibility and obligation to be aware of my insurance's requirements, coverages, deductibles and payments.

I have read and understand the policies of the practice, and I agree to be bound by its' terms. I also understand and agree that the practice may amend such terms from time to time.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health 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. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedure will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigation, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose 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 the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail / texts and/or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information

The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive a printed copy of this notice

Practice Duties

Law requires us law to maintain privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

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. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact us to let us know. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

_____
(please initial)

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

<><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><>

My Authorization to Release All Healthcare Information Including Mental Health

I hereby authorize the following person (s) to be involved with and receive information pertaining to my medical care including mental health. I understand that any and all information can only be given in person, and after presenting a picture ID.

I understand and agree that I have the right to revoke this authorization anytime by sending/giving a written notice to Mid Cities Psychiatry. And until I revoke this authorization in writing, this authorization is valid indefinitely.

Name	Address	Phone/Fax

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

Main Office Location

Mid Cities Psychiatry

200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
www.MidCitiesPsychiatry.com

My Authorization to Release All Healthcare Information Including Mental Health

To

Seema Kazi, MD dba Mid Cities Psychiatry

This is a release form for authorization of your medical information to be transferred between health care providers, health insurance companies and any other party involved in your medical care.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Social Security #	

I authorize the following facilities/hospitals and doctor(s) to release all medical information to Seema Kazi, MD dba Mid Cities Psychiatry for treatment consultation and to better manage my health.

This request includes: hospital summaries, echocardiogram reports, cardiac catheterization reports, laboratory reports, electrocardiograms, physician progress notes, labs, and any other healthcare information relating to my condition including my mental health progress notes.

I understand and agree that I have the right to revoke this authorization anytime by sending/giving a written notice to Mid Cities Psychiatry. And until I revoke this authorization in writing, this authorization is valid indefinitely.

List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:

Name	Address	Phone/Fax

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. See below below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. See below below.

D. For any mental/Behavior Health services	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. See above listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D. See above listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D. See above listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D. See above listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Patient Communication Consent & Acknowledgment of Privacy Practices

Mid Cities Psychiatry respects your privacy and requires your consent to communicate with you via phone, voicemail, email, or SMS/text messaging for purposes including, but not limited to, appointment reminders, test results, Billing and administrative matters, and other clinical information.

If you are unavailable, we request your permission to leave certain types of information on your answering machine, voicemail, email, or SMS/text message. Please fill out the following and then indicate your preference by checking Yes □ / No □ of the boxes below.

Communication Type	Voice Call (Cell)	Voice Call (Home)	E-mail	SMS/Text
Appointment Date & Time Reminders	Yes □ / No □	Yes □ / No □	Yes □ / No □	Yes □ / No □
Appointment Follow-Ups	Yes □ / No □	Yes □ / No □	Yes □ / No □	Yes □ / No □
Test Results	Yes □ / No □	Yes □ / No □	Yes □ / No □	Yes □ / No □
Clinical Information	Yes □ / No □	Yes □ / No □	Yes □ / No □	Yes □ / No □
Billing Matters	Yes □ / No □	Yes □ / No □	Yes □ / No □	Yes □ / No □

By selecting "Yes," you authorize Mid Cities Psychiatry to contact you using the selected communication method(s), including leaving voicemail messages or sending email and SMS/text messages if you are unavailable. This authorization includes permission to communicate limited protected health information (PHI) as reasonably necessary for the purposes listed above.

Electronic Communication Risks (Email & SMS)
By selecting "Yes," you acknowledge and accept the following risks:

- Unauthorized access, interception, or disclosure
- Misdelivery due to incorrect contact information
- Storage or backup beyond deletion
- Potential access by third parties (e.g., employers or service providers)
- Use as legal evidence

Mid Cities Psychiatry cannot guarantee the security or confidentiality of electronic communications.

This consent may be revoked at any time by written notification, except where action has already been taken based on prior consent.

Patient Acknowledgment and Agreement:
By signing below, you acknowledge that you have read and understand this consent, including the risks of electronic communication, and authorize Mid Cities Psychiatry to contact you using the methods selected above.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Medication Acknowledgement Form

Patient Agreement

I, _____ (patient's printed name), hereby consent to the following terms for my medication management, underlining my commitments and responsibilities to ensure effective treatment:

Terms Applicable to All Prescriptions:

1. **Appointment Adherence:** I commit to attending all scheduled appointments punctually.
2. **Urine Drug Screening:** I will provide a urine sample upon request within 48 hours. Inconsistent drug screen results with prescribed medications may lead to withholding of further prescriptions.
3. **Financial Responsibility:** I agree to pay all necessary fees at the time of my visits before receiving any services or prescriptions.
4. **Medication Management:** I will securely manage my medication, avoiding sharing, selling, or mishandling. Non-compliance may result in immediate termination of treatment.
5. **Compliance with Treatment Plan:** I will follow the prescribed treatment plan faithfully, engage in all recommended educational programs, and abstain from illegal or disruptive behaviors.

Specific Conditions Based on Medication Type:

- **General Psychiatric Medications:** Per my provider's recommendation, I will maintain regular appointments for continuous prescription management.
- **Attention Deficit Disorder (ADD) Medications:**
  - Routine psychiatric follow-ups as recommended by my provider.
  - Annual cardiac evaluation (EKG) monitored by my primary care physician.
  - Annual health assessment to confirm suitability for continued medication use.
- **Opioid Management with Buprenorphine:**
  - Zero tolerance for intoxication during appointments.
  - Medication dispensed only during scheduled clinic visits.
  - Mandatory disclosure of all other medications obtained from different healthcare providers.

Patient Acknowledgment:

I fully understand the responsibilities and risks associated with my treatment.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date

Patient Health Questionnaire (PHQ-9)

Please select each appropriate answer in the question as to over the last 2 weeks, how often have you been bothered by any of the following problems?
Use the following scale to choose the most appropriate number for each situation….

#s	Questions	frequency			
		Not At All	Several Days	More Than Half of the Days	Nearly Every Day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	Add Columns…….				
	Your PHQ-9 Scale Total Score Is….				

If you checked off any of the problems,
how difficult have these problems made it for you to do your work,
take care of things at home,
or get along with other people?

Not difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	

Mid Cities Psychiatry provides;

- Transcranial Magnetic Stimulation (TMS), a non-invasive and has minimal side effects, suitable for those preferring a non-drug approach.
- Esketamine offers rapid relief for severe, treatment-resistant depression
- Ketamine is used for its quick effects and potential long-term benefits to brain function.

The choice between these treatments depends on the patient's specific medical needs, severity of depression, and personal preferences. This decision is typically made by your provider, who evaluates all relevant factors.
Patient agrees to be contacted by a Patient Navigator Advocate to know more about these treatments.

_____ Yes _____ No

_____ Name of Patient _____ Date of Birth

_____ Signature of Patient or Responsible Party (if minor Patient) _____ Date

_____ Signature of Patient Representative (If Applicable) _____ Date

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

CSSRS Screening

If you marked 1, 2, or 3 on question #9 of the PHQ-9, please complete the CSSRS screening. Otherwise, skip this section please.

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

	YES	NO
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

Homicidal Ideations

Are you having Homicidal Ideations? ☐ Yes ☐ Yes and I am afraid I may act on them ☐ No

If you answered Yes or Yes and I am afraid I may act on them: Do You Have a Plan? ☐ Yes ☐ No

If you answered Yes: What is your plan? _____

Possession of Gun

Do you own a gun? ☐ Yes ☐ No

Rapid Mood Screener (RMS)

Are you among the millions of people who have depressive symptoms? Answer the following questionnaire about your medical history and provide it to your doctor or nurse to assist in an important conversation about your mood.

Please select one response for each question. You can complete the **RMS** in less than 2 minutes.

Patient Name _____ Date _____

	YES	NO
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	☐	☐
2. Did you have problems with depression before the age of 18?	☐	☐
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	☐	☐
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	☐	☐
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	☐	☐
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	☐	☐

Generalized Anxiety Disorder Questionnaire (GAD-7)

Please select each appropriate answer in the question as to over the last 2 weeks, how often have you been bothered by any of the following problems?
Use the following scale to choose the most appropriate number for each situation….

#s	Questions	frequency			
		Not At All	Several Days	More Than Half of the Days	Nearly Every Day
1	Feeling nervous, anxious or on edge?	0	1	2	3
2	Not being able to stop or control worrying?	0	1	2	3
3	Worrying too much about different things?	0	1	2	3
4	Trouble relaxing?	0	1	2	3
5	Being so restless that it is hard to sit still?	0	1	2	3
6	Becoming easily annoyed or irritable?	0	1	2	3
7	Feeling afraid as if something awful might happen?	0	1	2	3
	Add Columns…….				
	Your GAD Scale Total Score Is….				

Anxiety level based on score is;	no Anxiety (0-4)	mild (5-9)	moderate (10-14)	severe (15-21)

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (855) 295-2686
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

Current Providers

Primary Care Provider

Do you have a Primary Care Physician? ☐ Yes ☐ No ***If yes, then please fill 1-4, if No then please skip to number 4.***

1. Who is your Primary Care Provider?
2. When was your last visit to your Primary Care Provider?
3. When was your last Health & Physical?
4. Do you need help finding a Primary Care Provider? ☐ Yes ☐ No

Psychotherapist

Do you have a Psychotherapist? ☐ Yes ☐ No ***If yes, then please fill questions 1-3, if No then please skip to number 3.***

1. Who is your Psychotherapist?
2. When was your last visit to your Psychotherapist?
3. Would you be interested in exploring Psychotherapy services at Mid Cities Psychiatry? ☐ Yes ☐ No

Psychologist

Do you have a Psychologist? ☐ Yes ☐ No ***If yes, then please fill questions 1-3, if No then please skip to number 3***

1. Who is your Psychotherapist?
2. When was your last visit to your Psychologist?
3. Would you be interested in exploring Psychology services at Mid Cities Psychiatry? ☐ Yes ☐ No

Current Medical State - Stressors

Do you have Current Stressors? ☐ Yes ☐ No

If yes, please describe

Treatment Goal

What is your short-term treatment goal?

What is your long-term treatment goal?

Symptoms

Do you have Current Symptoms? ☐ Yes ☐ No

If yes, please describe

Medical History

Have you had any medical diagnoses (seizures disorders, diabetes, heart problems, other)? ☐ Yes ☐ No

If yes, then please fill questions 1-3, if No then please skip this section

1. Please list any medical diagnoses you have had

2. What was the date of each diagnosis?

3. Who was the provider for each diagnosis?

Surgical History

Have you had any surgeries in the past? ☐ Yes ☐ No

If yes, then please fill questions 1-3, if No then please skip this section

1. What procedure(s) did you have?

2. When was the date of each procedure?

3. Who was the provider for each procedure?

Family Medical History

Do you have biological family members with a medical history of seizures, disorders, diabetes, heart problems, or other conditions? ☐ Yes ☐ No
For each affected family member, please provide the following information: your relationship to them, whether they are alive, their age of onset for the condition, and their diagnosis.

Relationship	Alive (Yes/No)	Age	Diagnosis

Psychiatric History <> Psychiatric Diagnoses
Have you been diagnosed with any psychiatric disorders? ☐ Yes ☐ No
If yes, then please fill questions 1-3, if No then please skip this section

1. Please list any psychiatric diagnoses you have had:

2. What was the date of each diagnosis?

3. Who was the provider for each diagnosis?

Psychiatric Hospitalizations and/or Rehabilitation
Have you been hospitalized with psychiatric disorders and/or attended rehabilitation facilities? ☐ Yes ☐ No
If yes, then please fill questions 1-2, if No then please skip this section

1. What is the name of the hospital or rehabilitation facility?

2. When were you hospitalized or attended the rehabilitation facility?

Family Psychiatric History
Do you have any biological family members with psychiatric history? ☐ Yes ☐ No
For each affected family member, please provide the following information: your relationship to them, whether they are alive, their age of onset for the condition, and their diagnosis.

Relationship	Alive (Yes/No)	Age	Diagnosis

Previous Substance Use

Were you involved in Substance Use? ☐ Yes ☐ No

If yes, then please fill questions 1-6, if No then please skip this section.

1. What were the names of the substance(s)?

2. . How did you acquire these substance(s)?

3. What was the peak frequency of your usage for each substance? ☐ Continuous ☐ Episodic ☐ Binge

4. What route was the substance taken?

5. What age did you start using?

6. What age did you stop using?

Current Substance Use

Are you currently involved in Substance Use? ☐ Yes ☐ No

If yes, then please fill questions 1-6, if No then please skip this section.

1. What were the names of the substance(s)?

2. . How did you acquire these substance(s)?

3. What is your current pattern of use?

4. What is the peak frequency of your usage for each substance? ☐ Continuous ☐ Episodic ☐ Binge

5. What route are the substance(s) taken?

6. What age did you start using?

Psychiatric Medications

Have you previously been prescribed any Psychiatric Medications? ☐ Yes ☐ No

If yes, then please fill, if none, please skip this section

Medications	Dose	Start / End Date	Side Effects	Directions

Non-Psychiatric Medications

Have you previously been prescribed any Non-Psychiatric Medications? ☐ Yes ☐ No

If yes, then please fill question 1-5, if No then please skip this section

Medications	Dose	Start / End Date	Side Effects	Directions

Medication Allergies

Do you have any Medication Allergies? ☐ Yes ☐ No

If yes, then please fill question 1-2, if No then please skip this section.

1. What is the name of the medication(s) you are allergic to?

2. What were the reaction(s) you experienced?

Pharmacy

Do you have Pharmac(ies)? ☐ Yes ☐ No

If yes, then please fill question 1-4, if No then please skip this section

Name	City/State	Phone #

Legal History

Convictions

Do you have a Current or Previous Conviction? ☐ Yes ☐ No

If yes, then please fill question 1-4, if No then please skip this section.

Arrest date(s)?	Charge(s)?	Convicted?	Sentence(s)?

Probation

Are you currently on Probation? ☐ Yes ☐ No

If yes, then please fill question 1-2, if No then please skip this section.

1. Are you also on parole?

2. What is the ending date of your probation?

Lawsuits

Are you involved in any lawsuits? ☐ Yes ☐ No

If yes, then please explain below, if No then please skip this section.

Court Dates

Do you have any upcoming Court Dates? ☐ Yes ☐ No

If yes, then please fill question 1, if No then please skip this section

1. What are the reasons for your upcoming court dates?

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date