Mid Cities Psychiatry

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

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

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

Please allow us to thank you for choosing us as your psychiatric clinic. To serve you better, please make every effort to provide us the following at least 1 business day prior to your appointment;

- complete Registration and all other relevant forms
- complete meds-lists' name/directions/dose/durations/side effects

Our Nurse Practitioners, Physician's Assistants, Licensed Professional Counselors typically focus on comprehensive psychiatric treatment. Each Nurse Practitioners, Physician's Assistants, Licensed Professional Counselors along with Dr. Seema Kazi has specialized training in Psychiatry to deliver high quality specialty behavioral health services.

Medications and Refill Requests

- To request a refill your pharmacy MUST fax a refill request form to us at 855-295-2686 at least 4-5 business days before your medications end. Please allow at least 4 business days for refill requests to be completed.
- No refill requests will be processed on a weekend or holiday.
- CII prescriptions are highly controlled and followed by the Texas Prescription Program. A $25.00 fee will be charged for those requested between office visits.
- If you lose the prescription or need a refill; it will only be until your next scheduled appointment after provider's approval ($25.00 fee will be charged to you). If you do not have an appointment, we'll schedule an appointment for you asap.
- Some medications require a prior- authorization from your pharmacy. This may take 4-5 business days depending on your insurance.
- Patients requesting refills not been seen by a provider in last 60 days or more may be asked to make a follow-up appointment before a refill is considered.
- Patients may be considered an inactive patient if not seen by a provider or in contact with the provider in last four (4) or more months

Communication

- Our administrative staff handles all requests for appointments and correspondence. Every attempt will be made to return your call within 1 business day.
- As a general rule please use your appointment time with the provider wisely. Please discuss any questions/concerns of billing-charges or your balance/credit with our billing staff or our Practice Manager.

Termination of Physician-Patient Relationship

It is the policy of Mid Cities Psychiatry to maintain a cooperative and trusting physician-patient relationship with the patients. When such a physician-patient relationship has not been formed or the relationship is no longer proceeding in a mutually productive manner. The types of circumstances that can result in termination include but are not limited to, the following;

- Treatment / Follow-up nonadherence—Does not or will not follow the treatment plan and/or abuses the medication(s) and/or tampers with prescriptions/documents and/or repeatedly cancels follow-up visits or is a no-show.
- Verbal abuse—Patient and/or a family member and/or a friend is rude and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions, disturbs the practice's peace.
- Cannot be trusted—Deceptive and/or lies.
- Nonpayment—Failure to pay and/or consistent with our payment policy. Owes a backlog of bills and has declined to work with the office to establish a payment plan.

Guidelines for Continued Care

- Your appointment has been reserved exclusively for you and keeping your appointment is your obligation. As a courtesy, MCP will send you an appointment-reminder.
- MCP understands that your time and our providers' time is very important and that's why MCP doesn't overbook or double-book patient's appointments.
-

Mid Cities Psychiatry

- Patients are entitled under federal law to have access to their medical records and we follow all rules, guidelines and exceptions to ensure compliance to patient's rights. Please allow at least 4 business days to fulfill your request.
- If you need a phone session with a provider, please note that you will be billed at the standard office rate.
- For FMLA/STD/LTD or other forms to be completed, an appointment with a provider to be made.
- If medication has been prescribed continuously by the practitioner and inactive status occurs, a maximum of one month of medication may be prescribed while the patient finds an alternative healthcare provider.
- Inactive status may be instituted after three (3) missed appointments collectively in last 90 days.
- If you (or legal counsel on your behalf) request, summon and/or subpoena the participation and/or testimony of any Mid Cities Psychiatry an employee for any reason, including participation at trial, deposition or other the court or legal proceeding, you will be required to provide said employee's hourly rate for the estimated time of participation (three (3) hour minimum) or the payment as restricted by law forty-eight (48) hours in advance of the requested participation. The Mid Cities Psychiatry's employee shall be notified as soon as possible regarding said requested participation and/or testimony but at a minimum at least five (5) business days in advance of said event. Should notice fails to be provided in such a timeframe or payment fail to be made, Mid Cities Psychiatry may seek to quash or otherwise refuse to participate, and may seek reimbursement from you of any legal fees incurred as a result of seeking court protection against such participation.

Balances / Fees / Cancellation / Rescheduling / No-Show & Professional Services

- For any canceled or rescheduled appointment within 24 business hours or in case of a no-show, RCN Fee will be automatically charged to your credit-card on file as per RCN Fee schedule.
- Patients who arrive more than 15 minutes after their scheduled arrival time, will not be seen, will be rescheduled and charged to credit-card on file as per RCN fee schedule.
- Cancellation / Rescheduling / No-Show fee is nonrefundable. Emergencies may be considered with a proof and charges may be discounted/waived at the time of next appointment.
- Missed appointments will be documented in your records. If you no-show three (3) or more appointments in a 90 days period, we are to understand that you no longer need our services and may not be able to schedule an appointment for you; may use "Termination of Physician-Patient Relationship" listed above.
- MCP is under no obligation to render services to you if you cannot pay copays/co-insurance/deductibles or you are unable to clear your balance or unable to make the payment-plan. You will be rescheduled until all monies are paid or proper arrangements are made.
- We realize temporary financial problems may affect you to clear your account balance. Should this occur, please contact us ASAP to assist you.
- If the Amount due is not received by the payment-plan due date, you will be charged a late fee of $25.00. All your future appointments will be canceled any time payment-plan payment is missed.
- Upon missed payment-plan payment;
    - <u>your balance in full must be received before any future appointments can be scheduled</u>
    - <u>must be received by/before the 21st day of your missed payment-plan date or your past-due account may be referred to collections</u>
    - <u>your Psychiatrist-Patient relationship may be terminated.</u>

<u>Cancellation / Rescheduling / No-Shows (RCN) Policy</u>

Cancellations/Rescheduling in less than 24 business hours or No-Shows will be automatically charged as per RCN Fee schedule to credit-card on file. More than 15 minutes late to the appointment will be rescheduled and will be automatically charged as per RCN Fee schedule to credit-card on file.

_____ (please initial)

<u>Cancellation / Rescheduling / No-Shows Limit:</u>

Cancellation / Rescheduling / No-Shows Limit per 90 days is maximum one (1) _____ (please initial)

- RCN Fee Schedule;
    - All meds management 40 minutes appointment no-show fees would be $150.00
    - All therapists appointment no-show fees would be $150.00

All 20 minutes appointment no-show fees would be $75.00

Mid Cities Psychiatry

I, hereby authorize Mid Cities Psychiatry to debit my/our credit card account in the amount of $75 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

Mid Cities Psychiatry

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

Patient Financial Policy

To reduce confusion and misunderstanding between our Patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with us. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check (payable to Mid Cities Psychiatry), cash, debit card, Visa or Mastercard.

Your Insurance

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. **This offices' policy is to collect this co**-payment when you arrive for your appointment.

Your assistance in securing timely payments of your claims may be required. If your health plan requires that you obtain prior authorization in the form of a REFERRAL from your primary care physician (PCP), or PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.

If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send claims on your behalf. You should be aware however, that the Patients' share of the medical fees owed when using non-contracted physicians will usually be more than when using contracted physicians.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that will not be covered. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment of the balance that is designated as the Patients' responsibility is due upon receipt of a statement from our office.

We will bill your health plan for all services provided at Mid Cities Psychiatry. Any balance due is your responsibility and is due upon receipt of a statement from our office or from your insurance.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, or the parent or guardian with custody, for payments.

Keep in touch

Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. If your insurance company denies payment for services rendered by Mid Cities Psychiatry on grounds that the services are not medically necessary, this consent allows Mid Cities Psychiatry to collect payment from you for the services rendered. You will be responsible for services not paid by your insurance.

Mid Cities Psychiatry reserves the right to modify the Patient Financial Policy outlined herewith.

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.

Mid Cities Psychiatry

Your relationship to the Patient? _____

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

Mid Cities Psychiatry

200 Westpark Way, Euless, TX 76040
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Notice/Acknowledgement of Receipt 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.

Mid Cities Psychiatry

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.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Acknowledgement of Receipt of Notice of Privacy Practices

Mid Cities Psychiatry reserves the right to modify the privacy practices outlined herewith.

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

Mid Cities Psychiatry

Patient Communication Consent Form

From time to time, we may need to communicate with you and to preserve your privacy, we would like for you to indicate your preferred method for us to communicate to you. Examples of such information to be communicated include appointment dates, appointment reminders, appointment follow-up, test results, billing questions, and other information clinical in nature.

In the event that no one is available to answer your phone, we request your permission to leave certain types of information on your answering machine, voicemail, or email. Please fill out the following and then indicate your preference by checking Yes □ / No □ of the boxes below;

Name			
Add:		City/St/Zip	
Home		Cell	
E-mail		E-mail	

I give permission to Mid Cities Psychiatry personnel to leave the following forms of information pertaining to me on answering machine, voice-mail or e-mails listed below.

communication	cell #	home #	e-mail
appointment date/reminders	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
appointment follow-up	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
test results	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
information clinical in nature	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
billing questions	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐

This consent may be revoked at any time after written notification is received, except to the extent that action has been taken.

Share Your Experience With Us

Our #1 priority is your satisfaction. Your reviews are an important part of our practice. We'll send you an e-mail asking you to share your experience with us. Please note only your first name and last initial will appear on your review. Your email will not appear on the review and we will never share it with third parties.

please turn over

Mid Cities Psychiatry
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (817) 583-8923
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

Mid Cities Psychiatry

1. RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:
a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) Email senders can easily misaddress an email.
c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect email transmitted through their systems.
e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
f) Email can be used to introduce viruses into computer systems.
g) Email can be used as evidence in court.
h) Emails may not be secure, including at USC, and therefore it is possible that the confidentiality of such communications may be breached by a third party

2. CONDITIONS FOR THE USE OF EMAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:
a) Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.
b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
c) All email will usually be printed and filed in the patient's medical record.
d) Office staff may receive and read your messages.
e) Provider will not forward patient identifiable emails outside of Mid Cities Psychiatry without the patient's prior written consent, except as authorized or required by law.
f) The patient should not use email for communication regarding sensitive medical information.
g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted

3. INSTRUCTIONS

To communicate by email, the patient shall:
a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the email.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Provider of changes in his/her email address.
e) Acknowledge any email received from the Provider.
f) Take precautions to preserve the confidentiality of email

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with my treating physician or the Mid Cities Psychiatry Privacy Officer.

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

Medication Acknowledgement for ADD

By signing this agreement, I, _____ I agree to the following:
(patient's printed name)

1. To see my psychiatrist every month for my prescription for ADD.
2. To provide a urine sample upon request for a Urine Drug Screen, either at the office of Mid Cities Psychiatry or through an accredited laboratory within 48 hours of Mid Cities Psychiatry's request. If the Urine Drug Screen is (1) positive for substances not prescribed or (2) negative for medications prescribed by a medical professional engaged in my care and treatment, Mid Cities Psychiatry has the right to decline any further ADD prescriptions.
3. To have EKG done every year by primary care physician for ADD medication and have results present/faxed to Mid Cities Psychiatry.
4. To have a physical examination yearly by my Primary Care Physician for ADD medication.
5. To pay all office fees at the time of my visits before the service/prescription is rendered.

_____ _____

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

MID CITIES PSYCHIATRY
200 Westpark Way, Euless, TX 76040
office: (817) 488-8998 <> fax: (817) 583-8923
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

Mid Cities Psychiatry

Medication Acknowledgement for Opiate Management

I, _____ requesting that my doctor provide buprenorphine treatment for opioid _____ addiction. By signing this agreement, I agree freely and voluntarily to accept this treatment as follows:

1. To keep, and be on time to, all my scheduled appointments with the doctor and his/her assistant.
2. To conduct myself in a courteous manner in the physician's or clinic's office.
3. To pay all office fees at the time of my visits for random Urine Drug Screen at the office of Mid Cities Psychiatry before the prescription is dispensed.
4. Not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me and I will not be given any medication until my next scheduled appointment. Urine drug screens will be random (in urina latet veritas).
5. Not to sell, share or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
6. That the use of buprenorphine/naloxone (Suboxone) by someone who is addicted to opioids could cause them to experience severe withdrawal. Stopping buprenorphine in itself can cause opiate withdrawals.
7. Not to deal, steal, or conduct any other illegal or disruptive activities in or in the vicinity of the doctor's office.
8. That my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
9. That the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
10. Not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines, such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines.
11. To take my medication as the doctor, and his/her assistant has instructed, and not to alter the way I take my medication without first consulting the doctor.
12. That medication alone is not sufficient treatment for my disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my treatment.
13. That my buprenorphine treatment may be discontinued and I may be discharged from the clinic if I violate any of this agreement.
14. That there are alternatives to buprenorphine treatment for opioid addiction including:
    a. medical withdrawal and drug-free treatment
    b. naltrexone treatment
    c. methadone treatment

_____ _____

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

MID CITIES PSYCHIATRY
3801 William D Tate Avenue, Suite #800A, Grapevine, TX 76051
office: (817) 488-8998 <> fax: (817) 583-8923
info@MidCitiesPsychiatry.com <> www.MidCitiesPsychiatry.com

Seema Kazi, MD, PA

A. Notifier: Mid Cities Psychiatry, 200 Westpark Way, Euless, TX 76040
B. Patient Name: **C. MRN:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance doesn't pay for the item(s) or services listed below your provider has recommended, you may have to pay. *Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the* ***D.***_____ *below.*

D.	E. Reason Your 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.** _____ 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.** _____ listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me as an EOB. I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance** by following the directions on my EOB**.** If my insurance does pay, you will refund any payments I made to you, less co-pays or co-ins or deductibles.

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

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

H. Additional Information:

This notice gives our opinion, not an official your insurance decision.
If you have other questions on this notice, please call your insurance customer service.
Signing below means that you have received and understand this notice. You may request a copy of this notice.

I. Signature:	J. Date:

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.

Mid Cities Psychiatry

Medication Acknowledgement for Psychiatric Prescriptions

By signing this agreement, I, _____ I agree to the following:
(patient's printed name)

1. To see my psychiatrist as scheduled for Psychiatric Prescription.
2. To provide a urine sample upon request for a Urine Drug Screen, either at the office of Mid Cities Psychiatry or through an accredited laboratory within 48 hours of Mid Cities Psychiatry's request. If the Urine Drug Screen is (1) positive for substances not prescribed or (2) negative for medications prescribed by a medical professional engaged in my care and treatment, Mid Cities Psychiatry has the right to decline any further psychiatric prescription.
3. To pay all office fees at the time of my visits before the service/prescription is rendered.

_____ _____

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

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Seema Kazi, MD, PA

Mid Cities Psychiatry

Welcome to Mid Cities Psychiatry!

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

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 MCP. 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 _____

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Seema Kazi, MD, PA

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

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

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