Priti M Kothari, M.D., P.A.
Board Certified Child,
Adolescent & Adult Psychiatrist
9960 Central Park Blvd., N. Ste. 235
Boca Raton, FL 33428
Phone: 561-483-0844
Fax: 561-483-3342

Patient Name: _____ Today's Date: _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Male ( ) Female ( ) Other ( )

Parents (if patient is a child): _____

Patient SSN: _____ Patient DOB: _____ Patient Occupation: _____

Home Phone: _____ Voicemail Ok? _____

Work Phone: _____ Voicemail Ok? _____

Cell Phone: _____ Voicemail Ok? _____ Email: _____

Patient Status: Single ( ) Married ( ) Divorced ( ) Widow/er ( ) Other ( )

Referred by: _____

Patient's Physician: _____

If patient is child, School Name: _____ Grade: _____ Teacher: _____

Current Medication & Dosages: _____

Family members living with patient (Name, Relationship & Age):

_____

_____

Purpose of Visit: _____

History of Presenting Problem: _____

_____

Psychiatric / Psychological treatment history: _____

_____

Signature of consent for treatment: _____

Responsible Party (if patient is minor)

Name: _____ Home Phone: _____

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Address:_____ Work Phone:_____

City, State, Zip:_____ Cell Phone:_____

Email:_____ Male ( ) Female ( )

Signature of consent for treatment of Minor:_____

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I am choosing to enter psychiatry services with Priti M. Kothari, M.D., P.A.

As my appointment time has been set aside exclusively for me, I understand that I am responsible for the appointment fee, or a $50 cancellation fee, if I fail to cancel a scheduled appointment at least 24 hours in advance. **After (3) missed appointments I will be responsible for the full amount of my office visit fee.**

Initial:_____

I understand that payment is due at the time services are rendered.

Based on the information that I have provided the physician's office:

I agree to a Fee of $550 for the initial appointment.

I agree to a Fee of $275 for all follow-up appointments whether conducted in the office, phone consultation or via Zoom/Facetime.

Any balance overdue more than thirty days will be subject to a $25 late fee. I agree to pay the cost of any delinquent bill, including a reasonable attorney's fee and/or cancellation agency fee. I understand that my account may be sent to a collection agency or court if fees are not paid in a timely manner.

I fully understand and agree to the above policies and conditions.

Patient/Guardian:_____Date:_____

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PHARMACY FAX POLICY

Due to the heavy volume of incoming pharmacy faxes, Dr. Kothari requires that the patient or family member, if appropriate (consent on file) call for medication refill if needed. Office will not respond to pharmacy refill requests. Many faxes are on auto refill and it appears are not patient generated. Patient and/or family member agrees to call the office and not the pharmacy for refills. We require a 72-hour notice for prescription refills and prior authorizations.

Initial_____

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LIMITS OF CONFIDENTIALITY

The contents of an intake or assessment session are considered confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the patient or the patient's legal guardian. It is the policy of this practice not to release any information or written records about a client with another party without the written prior consent of the patient without a signed release of information. There are times we have a legal obligation to release information, these include the following:

1. Duty to Warn and Protect

When a client discloses intention or a plan to harm another person, the healthcare professional is required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

2. Abuse of Children and Vulnerable Adults

If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult) or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

3. In the Event of a Patient's Death

In the event of a patient's death the spouse or parents of a deceased patient, have a right to access their spouse or child's records.

4. Professional Misconduct

Health care professionals are required to report professional misconduct by a health care professional. In cases in which a professional or legal disciplinary meeting is being held regarding the healthcare professional's actions, related records may be released in order to substantiate disciplinary concerns.

5. Court Order

Health care professionals are required to release records of clients when a court order has been placed.

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6. Minors/Guardianship

Parents or legal guardians of non-emancipated minor patients have the right to access the patient's records.

7.Other Reasons Information May Be Released

By choosing to use your insurance for psychiatric services, we are required to release certain information to the insurance company at their request. Information which may be requested includes the following: type of services, dates/time of services, treatment plan, description of impairment, case notes and summaries.

When fees for services are not paid in a timely manner collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies and the client's credit report may state the amount owed, time frame, and the name of the practice.

Information about patients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases, the name of the patient, or any identifying Information, is not disclosed. Clinical information about the patient is discussed.

In some cases. notes and reports are dictated/typed within the practice or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. This information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries and (g) information that has been requested to be separate. The material disclosed in conjoint family or couples' sessions, in which each party discloses such information in each other's presence is kept in each file in the form of case notes.

One Effort We Make to Ensure Your Confidentiality is in Leaving Phone Messages:

In the event in which the practice or mental health professional must telephone the patient for purposes such as appointment cancellations or reminders or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we

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phone you at home or work, we do not say the name of the practice or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below), we will adhere to the following procedures when making phone calls: First we will ask to speak to the patient (or guardian) without identifying the name of the practice. If the person answering the phone asks for more identifying information, we will say that it is Dr. Kothari[t]s office calling and ask for a call back as appropriate. If we reach a voicemail, we will follow the same guidelines.

PLEASE CHECK PLACES WHERE YOU MAY BE REACHED BY PHONE.

Include phone numbers and how you would like us to identify ourselves when phoning you.

Home_____ May we say practice name, if not then what?_____

Work_____ May we say practice name, if not then what?_____

Cell_____ May we say practice name, if not then what?_____

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Patient's Name (print) Patient's (or Guardian's) Signature Date

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____

Phone#: _____

By signing this authorization, I authorize Dr. Priti Kothari to use and/or disclose certain protected health information (PHI) about:

Patient's Name" _____ to

Name of Individual/Group/Agency/Hospital/etc.: _____

Address: _____

Phone/Fax: _____

This authorization permits Dr. Kothari, M.D., to use and/or disclose to or obtain from other designated party listed above, specified individually identifiable health information about the above-named patient including but not limited to medical records, reports, and progress notes related to diagnoses, comprehensive medical history, drug and alcohol abuse history and treatment, legal history, HIV status and /or treatment, history of sexually transmitted diseases, treatment plan, and prognosis. Additional information may include the following: laboratory and imaging results, report cards, progress reports, educational testing, direct interview and any other information deemed appropriate by the specified individuals contacted and/or Dr. Kothari. .

The information will be used or disclosed for the of continuity of care, diagnosis, and direct treatment planning.

The purposes are provided so that I can make an informed decision whether to allow a release of the information. This authorization will only expire by written consent or formal termination of treatment. My written revocation must be submitted directly to Dr. Priti Kothari. I do not

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have to sign this authorization in order to receive treatment from Dr. Priti Kothari. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release Priti M. Kothari, M.D. from any and all liability that may arise from the release of information as I have directed.

Signature of Patient or Legal Guardian:_____

Relationship to Patient:_____

Date:_____

Witness:_____ Date:_____

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Credit Card Payment Authorization

I, _____

(Patient or Parent/Guardian name)

authorize **Dr. Priti Kothari** or **Jennifer Deyoe, NP**., to charge the following card for each office visit.

Amount to be charged: $_____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

Account/CC Number _____

Expiration Date _____ CVV _____ Zip Code _____

I understand that this authorization will remain in effect until I cancel, and I agree to notify of any changes. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card.

Signature _____ Date _____