Axial Psychiatric Services

Email: Info@AxialPsychiatricServices.com *Ankit Parmar, M.D, M.H.A.*

Patient Information

First Name:	Middle Initial:	Last Name:
Street Address:		Apartment #
City:	State:	Zip Code:
Date of Birth:	Age:	Gender: ○ Male ○ Female ○ Other
Best Phone:	Email:	
Legal Guardian Name (only if application)		Relation to patient:

Pharmacy Information:

Name:	Address:	Phone:

Emergency Contact Information:

Name:	Relationship:	Phone:

I certify that the above information is correct and that I give Axial Psychiatric Services permission to render services to me.

Patient/ Guardian Signature:

Patient/ Guardian Full Name:

Date:

Location: 6730 Horizon Rd, STE C, Rockwall, TX 75087
Phone: (972) 645-4874, Fax: (972) 947-5334

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CONSENT TO RELEASE PSYCHIATRIC / MEDICAL and/or ALCOHOL / DRUG ABUSE RECORDS

I, _____, D/O/B _____ hereby authorize Axial Psychiatric Services, to have bilateral exchange of information that is contained in medical record with (name of external entity): _____ under the conditions listed below:

1. This information will include any and all psychiatric. Medical/alcohol/drug abuse records unless otherwise stated here _____

2. Purpose or need for such disclosure: Continuing care/ Treatment/ Discharge Planning

3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon Discharge from the clinic.

4. An additional consent must be obtained for any other transfer or disclosure of this information.

5. I understand that I may receive a copy of this release.

Patient/ Guardian Signature: _____

Patient/ Guardian Full Name: _____

Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF Notice of Privacy Practices & HIPAA- HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT HIPAA CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Share clinical information with your insurance company.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Remind you of upcoming appointments, treatment options, or alternatives.

I understand that this office has the right to change its practices from time to time and that I may contact this office at any time to obtain more information.

Patient Name: Patient's D/O/B:

Patient/ Guardian Signature:

Patient/ Guardian Full Name:

Date:

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Payment and financial Policy

Axial Psychiatric Services is a cash-only practice as this allows us to maximize the amount of time we spend directly with our patients to meet their specific needs and avoid undue influence from insurance companies. After each visit, we are able to provide "Super bill" for services rendered which can be submitted to the insurance company to get out-of-network reimbursement.

- Payment is due at the time services are rendered. An email/ secure message invoice will be generated on the day of the service for online payments. Payment rates are stated on the website and it is patient/ guardian's responsibility to check for any updates in the rates.
- No-Show and Late Cancellation fees: When you set up an appointment, you are reserving that provider's time and in the process guaranteeing that you will be present for the appointment. Any arrivals after 15 minutes of scheduled appointment time will be treated as a no-show and may be requested to reschedule appointment. If an appointment is canceled without 48-working-hours notice or an appointment canceled same day, you will be charged the full fees as per the schedule stated on the practice website.
- Any assistance with court related matters including court hearings, preparation of report, traveling, etc will be billed at an hourly rate of $500.
- Patients will incur additional fees for assistance with submission of any forms, telephone encounters or other services not provided during the clinic visit.
- Preferred Method of payment: ○ Credit Card ○ Cash ○ Personal Check ○ Online Transfer (Zelle)

☐ By checking this box, I provide consent to Axial Psychiatric Services to securely save my payment information and charge me on the day of my scheduled visit at the rate stated on the Axialpsychiatricservices.com website.

Patient Name: _____ Patient's D/O/B: _____

Patient/ Guardian Signature: _____

Patient/ Guardian Full Name: _____

Date: _____

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Patient Online Portal Use Disclaimer and Policy

- Axial Psychiatric Services offers its patients an opportunity to use secure patient portal. It's purpose is solely to maintain secure communication with the providers of the Axial Psychiatric Services. By signing this policy and opening an account on the portal, you agree to the following terms of use:
    - **DO NOT USE PORTAL TO COMMUNICATE MEDICAL OR PSYCHIATRIC EMERGENCIES. PLEASE CALL 911 IF YOU NEED IMMEDIATE HELP WITH YOUR SITUATION.**
    - Messages left on the portal will be answered in a case by case basis at the discretion of staff and providers. After-hour messages will be answered the following business day.
    - Please be aware that the communication shared via the patient portal is HIPAA compliant; however, if communication is shared via regular text messages, it may not be secure.
    - Allow Axial Psychiatric Services to send electronic communication, via emails or text messages, regarding my appointments, payment, and pertinent medical records.
    - Terms and conditions of the individual cell phone carrier will apply when sending text messages without using the secure portal.
    - When you open an account on the portal, you agree to share any and all patient related information using this portal. It you the responsibility of the patient/ guardian to make sure that the portal is secured on your device in order to limit unauthorized use.
    - Axial Psychiatric Services or its officers and providers do not assume any liability for the materials, information, and opinion provided on, or available through, the patient portal. You agree to indemnify and hold harmless staff and providers from and against all liabilities, expenses, damages, and costs, including attorneys' fees, arising from any violation by you of these terms of use.

Patient Name: _____ Patient's Date of Birth: _____

Patient/ Guardian Signature: _____

Parent/ Guardian Full Name: _____

Date: _____

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