Nirmal Singh Brar, M.D., Inc.

Diplomate of the American Board of Psychiatry and Neurology
Child, Adolescent & Adult Psychiatry

1111 E. Hendon Ave., Suite 115
Fresno, CA 93720
(559) 376-7921 FAX (559) 335-4214

Welcome

We would like to welcome you to our practice and we are pleased to have you as a patient. We are providing you with the following information to help you understand how this office operates. Every effort will be made to treat you with courtesy and respect. Please read this information carefully and write down any questions that you might have so that you can discuss them with our staff.

General Information

It is your responsibility to contact your insurance company to confirm that the doctor is on your insurance panel, acquire pre-authorization for treatment, and confirm benefits for "**Outpatient Mental Health**" services before your first appointment. Be sure to state that this is for "outpatient mental health" benefits; otherwise the insurance personnel may quote you the benefits for major medical services instead.

Please arrive **15 minutes** prior to the first appointment.

You must have your paperwork completely filled out prior to you arrival, along with your insurance card(s) and any other paperwork requested by our office. **YOU WILL NOT BE SEEN BY THE DOCTOR UNLESS ALL FORMS ARE COMPLETELY FILLED OUT PRIOR TO YOUR VISIT**.

Upon arrival at the office, always check in with the receptionist so that the doctor can be informed that you have arrived.

If you have any questions, please feel free to contact our office at (559) 376-7921.

Emergencies

In the event of an emergency you should call "9-1-1" to access emergency medical services. Otherwise, free evaluations can be obtained at Community Behavioral Health Center, 7171 N. Cedar Ave, Fresno, California, (559) 449-4434. For children and adolescents, call Exodus Recovery, Inc. at (559) 600-2382. You may also call the Suicide Hot Line at (888) 506-5991.

If you need to contact the doctor between sessions, please leave a message with the office and your call will be returned as soon as possible. **Calls made between 5:00 p.m. and 8:00 a.m. should be of an urgent or emergency nature only.** In the event that the doctor is unavailable due to illness, vacation, or other circumstances, emergency calls will be forwarded to the on-call doctor.

Financial Policy and Code of Conduct Policy

As your mental health provider, we are committed to providing you with the best possible care. In order to achieve this goal, we need your cooperation and your full understanding of our Financial Policy and our Code of Conduct Policy.

Payment is due at the time services are rendered: This office accepts cash, personal checks, Visa and MasterCard. Returned checks are subject to a service charge of $25.00 and you may lose your privilege to write checks in our office. The patient/responsible party is responsible for payment of co-pays, coinsurance, deductibles and noncovered services at the time of service. For patients without insurance or with insurances that this office is not contracted with, payment is due in full at the time services rendered. **If you are not prepared to pay at the time of your appointment it may be necessary to reschedule your appointment.**

_____Patient/Responsible Party Initials

For patients with insurance: As a courtesy, this office will bill your insurance, if proper insurance information is provided at the time of service. The patient/responsible party will be held responsible for providing their insurance information at every visit. If your insurance requires a referral or prior authorization, it is your responsibility to assure that one has been provided to our office prior to or at the time of your scheduled appointment. It is the patient/responsible party responsibility to verify you are receiving care from a contracted provider, as we are not a provider for every insurance carrier.

_____Patient/Responsible Party Initials

Non-covered services: It is the patient/responsible party's responsibility to know their insurance plan benefits. All service charges not covered or denied by your insurance carrier are the responsibility of the patient/responsible party and payment will be due immediately or upon receipt of denial. It is the responsibility of the patient/responsible party to handle denials directly with their insurance carrier.

There are some services that are not covered by insurance that require the doctor's time and must be paid for at the time services are rendered. These include:

- Provide copies of patient records to other than treating physicians: $25.00
- Fill out forms (other than insurance related forms): $25.00 / 10 minutes
- Letters and additional reports: $25.00 / 10 minutes
- Requested telephone contacts with other than with the patient/parents: $25.00 / 10 minutes

_____Patient/Responsible Party Initials

Medicare patients: This office does not accept Medicare.

_____Patient/Responsible Party Initials

Missed appointments: In fairness to other patients and to the doctors, this office requires 24 hour notice for cancellation of appointments. **There will be a $100.00 no show fee assessed to your account for missed appointments or in the event you do not provide 24 hour cancellation notice for patients with commercial insurance and cash pay.**

_____Patient/Responsible Party Initials

Past-due accounts: Accounts unpaid for more than 60 days will result in the prevention of scheduling any future non-emergency appointments until the account is paid in full or brought to a current status. Accounts unpaid for more than 90 days will be turned over to a collection agency and may result in dismissal from the practice.

_____Patient/Responsible Party Initials

Accounts referred to collections: If your account is turned over to a collection agency, you are required to direct all correspondence to the collection agency and not our practice. You will also be responsible to pay the collection agency for any additional fees assessed, such as accrued interest fees and legal fees.

_____Patient/Responsible Party Initials

Assignment of benefits: I hereby assign and authorize payment of any insurance benefits directly to Nirmal Brar, M.D., Inc. and/or its providers. Photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance plan(s). This assignment shall remain in effect until revoked in writing. I hereby authorize said assignee to release all necessary information to secure payment.

_____Patient/Responsible Party Initials

Financial agreement: We will gladly discuss any questions relating to your account. However, we must emphasize that, as your mental health care providers, our relationship and concerns are with you and your health, not your insurance company. Not all services are covered by all insurance plans and some insurance carriers will have treatment exclusions. **All charges, including plan exclusion, are the Patient's/Responsible Party's responsibility from the time services are rendered.** We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, we encourage you to contact our office to discuss payment arrangements.

_____Patient/Responsible Party Initials

Code of Conduct Policy: Our office believes in mutual respect to and from our patients. Therefore, we have established a **Zero Tolerance Policy** against any verbal or physical abuse to our doctors and/or to our staff members. Any form of such abuse or violence will result in immediate dismissal from the practice.

_____Patient/Responsible Party Initials

have read the above Financial Policy and Code of Conduct Policy and I fully understand and agree to the terms specified. I also acknowledge that I have been provided with a copy of the signed policy.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Print Patient Name Account Number

_____ _____

Witness Signature (Office Staff Member) Date

PATIENT AND BILLING DATA

Who referred you to this office? _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

What is the **patient's** relationship to the Responsible Party (Person who will pay the balance after insurance pays)?
☐ Self ☐ Daughter ☐ Son ☐ Granddaughter ☐ Grandson ☐ Other: _____

If the patient is a minor, where does the minor reside? ☐ Both Parents ☐ Mother ☐ Father
☐ Both Grandparents ☐ Grandfather ☐ Grandmother ☐ Guardian ☐ Other: _____

ACCOUNT RESPONSIBLE: (If other than the patient)

☐ Both Parents ☐ Mother ☐ Father ☐ Both Grandparents ☐ Grandfather ☐ Grandmother
☐ Guardian ☐ Other: _____

Name: _____ Date of Birth: _____
Title (Please check one): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

Primary Care Physician: _____
Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip Code: _____

In case of emergency, contact: _____
Relationship of emergency contact to the **patient**: _____
Phone numbers of emergency contact: _____

Is your condition work related? ☐ Yes ☐ No
If referred by an attorney or litigation is pending:

Attorney: _____
Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip Code: _____

PRIMARY INSURANCE COMPANY:

Company: _____ Attention: _____
Mailing Address (for mental health claims): _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Ext: _____ Fax: _____

INSURED: (The person who is the policy holder) ☐ Same as Account Responsible
Name: _____ Date of Birth: _____
Title (Please check one): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

Employer: _____ ID/SS#: _____
Group Claim #: _____ Group Name: _____

Patient's relationship to the insured: ☐ Self ☐ Daughter ☐ Son ☐ Granddaughter ☐ Grandson
☐ Other: _____

SECONDAY INSURANCE COMPANY:

Company: _____ Attention: _____
Mailing Address (for mental health claims): _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Ext: _____ Fax: _____

INSURED: (The person who is the policy holder) ☐ Same as Account Responsible
Name: _____ Date of Birth: _____
Title (Please check one): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

Employer: _____ ID/SS#: _____
Group Claim #: _____ Group Name: _____

Patient's relationship to the insured: ☐ Self ☐ Daughter ☐ Son ☐ Granddaughter ☐ Grandson

RELEASE OF INFORMATION:

Patient Name: _____

I hereby provide authorization for Nirmal S. Brar, M.D., Inc. to exchange information regarding the medical and psychological condition, Genetic labs or diagnosis and drug and alcohol treatment of the patient named above with:

(This authorization is subject to revocation by the undersigned at any time except to the extent that action based on my authorization has already been taken. I understand that revocation must be in writing. A copy of this authorization/request is to be as valid as the original.

I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such disclosure. This authorization/consent is given freely and I have not been threatened with discontinuance or refusal of service if I do not sign this form)

_____
(Name of Patient's Personal Physician)

_____
(Name of additional Individual or Agency)

_____
(Name of additional Individual or Agency)

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby provide consent for Nirmal S. Brar, M.D., Inc. to perform a psychiatric evaluation, and/or provide treatment to myself or my dependent.

Signature: _____Date: _____

CUSTODY ORDER VERIFICATION
(ONLY FOR MINOR PATIENTS)

Minor Patient Name: _____

In cases where the patient is a minor and the patient's parents are separated or divorced, or legal guardianship exists, we require that you specify the current Legal and Physical Custody status of your minor child.

Joint Legal Custody can be awarded separate from Joint Physical Custody. Joint Legal Custody means that either parent acting alone may consent to mental health treatment unless the order of Joint Legal Custody has language to the contrary. Orders specifically requiring shared medical decision making responsibilities (barring emergencies) will require the consent of both parents.

If you need help determining your rights to obtain and authorize mental health treatment for your child, please contact your legal representative.

Indicate below the legal and physical custody status of the minor child:

☐ Joint legal custody allowing either parent to consent to mental health treatment.
☐ Joint legal custody requiring both parents to consent to mental health treatment.
☐ Sole legal custody. (Name of person with legal custody: _____)
☐ Joint physical custody.
☐ Sole physical custody. (Name of person with physical custody: _____)
☐ There is **no record of any Custody Order** for this patient.

Your signature below certifies that you have provided correct and accurate information regarding your Custody Order and your ability to authorize mental health services for your minor child in the event of separation, divorce or legal guardianship.

_____ _____

Signature of Parent/Legal Guardian Date

NOTICE OF PRIVACY PRACTICES

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with this Notice which provides a summary the health information privacy practices of Nirmal Brar, M.D., Inc. A full copy of our current Notice will always be posted in our reception area. You will also be able to obtain your own full copy at our website www.NirmalBrarMD.com, by calling the office at (559) 376-7921 or asking for one at any time.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a patient or receiving treatment or other health-related services from us;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future; or
- information about your health care benefits under an insurance plan;

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); or
- other types of information that may identify who you are.

REQUIREMENT FOR WRITTEN AUTHORIZATION

We will obtain your written authorization before using your health information or sharing it with others outside Nirmal Brar, M.D., Inc., except as we describe in this Notice. Uses and disclosures of health information that require your written authorization include: most uses and disclosures of psychotherapy notes, most uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information. Other uses and disclosures not described in this Notice or otherwise permitted by HIPAA will be made only with your written authorization. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to Nirmal S. Brar, M.D., Inc. at 1130 E. Shaw Avenue, Suite 105, Fresno, CA 93710.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information.

1. Right To Inspect and Copy Records.
2. Right To Amend Records.
3. Right To an Accounting of Disclosures.
4. Right To Request Additional Privacy Protections.
5. Right To Request Confidential Communications.
6. Right To Have Someone Act On Your Behalf.
7. Right To Obtain a Copy of Notices.
8. Right To File A Complaint.
9. Right To Be Notified Following a Breach of Unsecured PHI.

By signing below, I acknowledge that I have been provided a summary of the Nirmal S. Brar, M.D., Inc. Notice of Privacy Practices, have been informed how I may obtain a full copy, and have therefore been advised of how health information about me may be used and disclosed by Nirmal S. Brar, M.D., Inc. and how I may obtain access to and control this information.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority