M.Z.Uddin MD PC

1333 Howe Ave #113
Sacramento, CA, 95825

We are honored that you have chosen us as your mental health provider. Our goal is to provide the highest quality of care for all of our patients in both a timely and respectful manner.

To your first appointment, please bring:

- **Your insurance card(s)**
- **Your photo ID**
- **A debit/credit card**
- **If you require a hearing aid and/or glasses, please ensure that you bring them to your Appointment.**

Please notify our staff if any of your information has changed since your phone intake. If you neglect to bring the required materials (insurance cards, photo ID, debit/credit card, and any required hearing aids/glasses when applicable) to your appointment then you will need to be rescheduled. Any patients with a legal representative over their medical attorney (Power of Attorney/Conservator) must have such present at each appointment. Please bring a list of your current prescriptions and over-the-counter medications with you to every visit.

You will be asked to fill out a new registration form annually to ensure that we have your most up-to-date information. Enclosed is your initial registration packet, please make sure to complete it in full and bring it with you to your first appointment.

We suggest that you allow plenty of time to get to the office for you appointment. You may be asked to reschedule your appointment if you are more than 10 minutes late and cancellation fees will apply. From time to time a patient emergency may potentially arise causing office staff to fall behind on scheduled appointment times. In the event of this circumstance, you will be given the option to reschedule your appointment at no charge or you can wait. If you choose to stay and wait for your appointment, we will do our best to keep you well informed of any further time delays.

All copayments are due at the time of service. We accept cash and debit/credit cards. Checks are NOT accepted for copayments.

Missed appointment policy:

- **New patients will be charged $100 for no-shows. patients must call at least 48 hours prior to their appointment to avoid this fee. You may call any day of the week, including weekends and holidays.**
- **To cancel your appointment, call (916) 333-1511. If the office is closed at the time of your call, be sure to leave a detailed message.**
- **Cancellation fees may be waived with a doctor's note stating that you received same day care in their office. You will be asked to provide proof.**

Congratulations on taking the first step in maintaining your mental health. We thank you for choosing M.Z.Uddin MD PC.

Sincerely,

Provider and Staff

PATIENT SERVICES AGREEMENT M.Z.Uddin MD PC:

Welcome! M.Z.Uddin MD PC practices in adult psychiatry where various psychiatric illnesses and disorders related to substance abuse/dependence are treated. Our goal is to help you stabilize and maintain your mental health so that you may achieve a higher quality of life. Set forth below is our Patient Services Agreement, which establishes guidelines for your participation in treatment with us. If, after reading and considering the tariffs of this agreement, you agree to everything set forth herein, please sign and initial where indicated.

TERMS AND CONDITIONS

1. **Payment for Services:** I agree that I am required to pay in full for the services rendered by this office, regardless of whether my insurer covers such expense. It is understood and agreed that whether I am signing as an agent or a patient, in consideration of the services to be rendered, I hereby individually obligate myself to pay the account of this office in full in accordance with its rates and charges. I understand that the designated billing company will mail two statements via USPS to my address, that I have provided, in regards to any balance owed. If there is a lapse in payment exceeding a 90-day period, I understand that my account will be referred to collections and that I will be discharged for nonpayment from the care of Muhammad Uddin/ or Jawad Arif MD. and the office of M.Z.Uddin MD PC. Should my account be referred to collections, I agree to pay the delinquent amount and I understand that interest rates may apply at the legal rate. Payments may be made via check, cash, or credit card and can be paid at the office or by USPS to the office address (1333 Howe Ave, Suite 113, Sacrament0, CA, 95825) and **I understand there is a $35.00 penalty fee for any returned (bounced) checks.** I understand that office staff will have no access to account balances, owed or overdue bill amounts, or future/current contractual rates unless otherwise provided by the billing company for the means of payments or collections. **There is a $25.00 fee for any forms required to be filled out by my provider and I am aware that there is a ten business day allowance for processing and submission of any paperwork from this office.**

Initial: ____

2. **Assignment of Insurance Benefits: Whether signing as a patient or as an agent, I authorize direct payment to this office of any insurance benefits otherwise payable to me for my treatment by this office and/or charges relating thereto. I also acknowledge and understand that I remain financially responsible for charges not covered by my insurance provider, for any reason. I acknowledge that insurers do not always pay the full amount for rendered services, including but not limited to: the preauthorization for services, quoted patient responsibility, and provided policy coverage details. There will be a 60 day grace period to allow for receipt of payment from the insurer and thereafter I understand that I am solely responsible for the balance owed and will be billed accordingly. I understand that I will be expected to make a payment within 10 business days following said grace period.** Thereafter, I may be subjected to interest charges at the legal rate and treatment may be discontinued immediately.

Initial: ____

3. Managed Care Plan: It is my responsibility to know and understand my managed care plan. Generally, insurance plans require payment of deductions and/or co-payments. I understand that if M.Z. Uddin MD contracts with my insurer, this office will only file patient insurance claims if I provide them with the proper information, along with a copy of my current insurance card and/or other sufficient proof of insurance. In the event that an insurer overpays, this office will refund the overpayments to me within a reasonable time after written request. Otherwise, overpayments will be credited to my account for future services.

Initial: ____

4. Termination Policy: I understand that this office has the right to discontinue services at any time, without limitations, for any reason. Reasons may include: failure to attend a scheduled appointment, failure to reasonably communicate or cooperate with the treating physician and staff, and/or failure to comply with prescribed treatment requirements. Likewise, I am aware that my treatment is “at will” and I reserve the right to terminate or refuse treatment (including medication) at any time. While undergoing any treatment, I agree to immediately inform M.Z.Uddin MD PC of anything pertaining to or effecting my treatment. I commit to achieving my treatment goals by effectively communicating with this office.

Initial: ____

5. Prescriptions: I understand that **it is my responsibility to track refill needs on my medications and that I need to contact my pharmacy (not this office) for my refill needs.** I acknowledge that this office requires a **seven day** notice for refills for any controlled or pre authorized medications to prevent a lapse in medication. I understand that I must contact my pharmacy for refills and that this office requires a faxed refill request from my pharmacy to process any refills and that not doing so will prolong the process and receipt of my medication. I understand that I am responsible to pay for my medication if it is not covered by my insurance provider and for attaining a list of prescribed medication through my insurance provider. I understand that it is not the responsibility of this office or the provider to attain an approved medication list and therefore, the provider is unable to prescribe medication based on my pre-approved medications, per my policy. Furthermore, I understand that it is my responsibility to attain a list of approved medications and give it to my provider so that I may avoid a lapse in medication due to the necessary prior authorization approvals for medications which are not covered by my insurance. I am aware that this office processes prior authorizations as a courtesy to the patients and that is not a requirement for treatment, nor are there any rules/laws mandating the processing of the medication authorization requests. The office policy is **14 working days** to submit the
request to my insurance company and I understand, that in the event there is a denial for an authorization, this office will not seek further actions. It is the right and at the discretion of the provider to retract this courtesy at any time for any reason without explanation. Requests for authorizations are done only for medications where the cost is more than**$50.00** for a 30 day supply. M.Z.Uddin MD PC. will give timely notification to patients when/if the processing of medication authorizations are no longer available as a courtesy. Any requests given prior to the date of retraction will still be honored and processed accordingly.
Initial: ____

6. Cancellation Policy: I agree to and understand that per policy at M.Z.Uddin MD PC, there is a (**$75.00 existing patients/$100 new patients)** charge for any missed appointments or for failing to give notification of cancellation, no less than **48 hours** prior to my appointment. **If I am more than 10 minutes late for my scheduled appointment, I accept that my appointment will be cancelled and the above charges will apply.** If the office is closed for weekend/holiday and a cancellation is necessary, it is acceptable to leave a voice message or opt to cancel through the text message reminder service. I acknowledge that this office does not provide courtesy

reminder calls for appointments and I agree that it is my responsibility to attend my scheduled appointments, as well as follow up to reschedule any cancelled appointments. As a courtesy and to maintain the health of the office's patients and staff, M.Z.Uddin MD PC, allows patients one cancellation (per calendar year, October-February ONLY) beyond the 48-hour time frame and without penalty, if the patient has Influenza. I acknowledge that in order to redeem this courtesy, I am still required to call and inform staff of my absence no later than 2 hours before my scheduled appointment time.
Initial: ____

7. Release of Information: I authorize and consent for this office to disclose necessary information, including portions of my patient/medical records, to any person or corporation that is/may be liable for any portion of my offices charges for services rendered to the extent necessary in order to determine liability for payment and to allow this office to obtain reimbursement this includes, but is not limited to: insurance companies, health care service plans, and/or workers compensation carriers.
Initial: ____

8. Informed Consent: I am aware that I have the right to know all risks, benefits and treatment alternatives before consenting to any treatment with the exception of simple/common procedures and in emergency situations. I also understand that I have the right to refuse treatment by withholding consent.
Initial: ____

9. Arbitration: I understand that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this Patient Agreement were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. I understand this arbitration agreement applies to any legal claim or civil action in connection with these services, including but not limited to a dispute as to medical malpractice against M.Z.Uddin MD PC, or its employees, agents, or representatives unless I initial below or unless rescinded by my

written notice within 30 days of signature. Arbitration will be in accordance with the current Medical Arbitration Rules of the California Medical Association and the California Association of Hospitals and Health Services.
Initial: ____

This Agreement to arbitrate is not a precondition to the furnishing of services under this agreement. If I **do not** agree to arbitration, then I will initial here: ____

10. Partial Invalidity: I understand and agree that if any provision of this agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way.
Initial: ____

11. Governing Law: I agree that this agreement will be governed by and construed in accordance with the laws of the State of California.
Initial: ____

PRIVACY AND CONFIDENTIALITY
A. I understand that confidential maintenance of patient records is integral to patient care and the practice of health information management. In addition to the federal Health Insurance Portability and Accountability Act (HIPAA), which includes privacy regulations, California has several state laws governing health information privacy, such as the Confidentiality of Medical Information Act, California patient access to health records act and the Lanterman-Petris-Short Act. The state information practices act also governs the acquisition and use of data that permits to individuals and all of these laws establish protections to preserve the confidentiality of various medical and consumer information and disallow disclosure of personal information except as authorized by law or with my consent.
Initial: ____

B. I am aware that this office uses personal information to treat patients and refer them to specialists. This office also uses patient information to bill insurance providers. If I do not want insurance companies to access my health information, I understand that I must pay cash for medical services. Further, I am aware that this office is subject to mandatory reporting of violence. This office may report my personal health information if there are reasonable grounds to believe disclosure is necessary to eliminate or reduce significant risk of serious bodily harm to a person or group of persons. I understand these reporting obligations and rights are not exhaustive.
Initial: ____

C. I understand that I have the right to obtain complete information about my medical condition and care and the right to inspect my medical records within 5 days of asking via written request to this office. I acknowledge that if I choose to request my medical records, there is a .25 fee per page. M.Z.Uddin MD PC is unable to view the number of pages in my records. Consequently, I understand that it is my responsibility to pay for my records in full. I also understand I may terminate or refuse treatment at any time.
Initial: ____

Credit/Debit Card Agreement
I agree, per policy of .Z.Uddin MD PC, to provide a valid copy of a debit or credit card to be kept on file for purposes of due charges for missed/no show appointments or cancellations outside of the timeframes agreed upon in section 6 of this contract. I consent for M.Z.Uddin MD PC, to charge my debit/credit card for any fees incurred due to non- compliance of the policies set forth.
Signature of Patient: _____ Date: _____

PATIENT'S CONSENT TO TREATMENT OR PROCEDURE

I , the undersigned, consent to treatment or procedure by Dr Muhammad Uddin/ or Dr Jawad Arif and have been duly informed of the nature, risk, and possible complications and consequences, and available alternative methods of treatments. I understand that this treatment and/or procedure is for the relief of _____, and hereby consent to this treatment to be performed by or under the direction of Dr Muhammad Uddin/ or Dr Jawad Arif . I understand that the practice of medicine and surgery is not an exact science and have neither asked for nor received any guidelines or promises as to the results which will be obtained.

I, the undersigned, certify and acknowledge that I have read and understood the content of this contract, or content has been explained to me by an authorized general agent, and accept all terms of this contract.

Print Patient/Agent Name: _____Signature of Patient/Agent: _____

Date: _____

Primary Care Physician/Referring Provider: _____

Date Last Seen: ___/___/___

Patient Information:

Last Name: _____ First Name:_____ _____ MI: _____ Gender(circle one): *Male/Female*

Race(circle one): American Indian or Alaska Native Asian Black or African American Hispanic or Latino Native Hawaiian or Other Pacific Islander White Other

Ethnicity:

_____

_ Marital Status(circle one): Single Married Widowed Divorced Separated

SSN: _____-_____-_____ DOB: _____/_____/_____ AGE: _____ Maiden Name:

_____

Address:

_____

__ City: _____ State: _____ Zip Code: _____ Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Employment status: _____ Employer: _____*Reason for Visit:*

_____

For your convenience, we offer a reminder text service for your appointments (we do not make reminder calls). Once you're added to the reminder text service, you need to verify this information via email. (Please check your spam if you have not received the information).

Cell Phone Number for Reminders:

_____ **Email Address:**

_____**Reminder: Missed appointments are subject to a cancellations fee.**

Emergency Contact:

Name: _____ Relationship: _____ Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Next of Kin:

Name: _____ Relationship: _____ Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Medical Information:

Pharmacy:

_____

Pharmacy Address:

_____

Past Psychiatric Care:

Past Therapists and Psychiatrists (Please list the names of past providers and dates seen):

_____

_____ _

Allergies: Circle ALL applicable. Adhesive/Tape
Anticoagulant
Therapy
Aspirin Codeine
Demerol Ibuprofen
Iodine
Local Anesthetics Latex
Nuts
Seafood
Sulfa Drugs
Other: _____
Smoking:
Current Smoker?_____ Years Smoking: _____ Packs Per Day: _____ Quit Smoking?_____/____/_____
Medical History:
AIDS/HIV
Allergies to
Anesthetics
Anemia
Angina
Arthritis
Artificial Heart Valves/Joints
Asthma
Back Problems
Bleeding Disorders
Cancer
Chemical Dependency
Chest Pain
Circle to indicate if you have had any of the following:
Chronic Diarrhea Diabetes Epilepsy
Fainting
Gout
Headaches
Heart Disease Hemophilia Hepatitis/Jaundice High Blood Pressure Hypothyroidism Hyperthyroidism
Kidney Problems
Liver Disease
Radiation Treatment
Rash
Respiratory Disease
Rheumatic Fever
Shortness of Breath
High Cholesterol
Stroke
Tuberculosis
Ulcers
Weight Loss; Unexplained
Low Blood Pressure Neuropath

Other:_____

Insurance Authorization and Assignment

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/INSURANCE COMPANY BENEFITS BE MADE TO M.Z.Uddin MD PC, FOR ANY SERVICES RECEIVED BY ME. I AUTHORIZE HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO M.Z.Uddin MD PC AND ITS AGENTS ANY INFORMATION NEED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM IN MEDICARE OR INSURANCE COMPANY ASSIGNED CASES. THE PHYSICIAN AGREES TO ACCEPT THE DETERMINE BY MEDICARE OR MY INSURANCE COMPANY AS PAYMENT IN FULL. I AM RESPONSIBLE FOR ANY DEDUCTIBLE, COINSURANCE, OR NON-COVERED SERVICES.

SIGNATURE: _____

DATE: _____

Please select the medications listed below that you have taken before and circle one dose you have had for that medication. Also, please try to remember which month and year you took each medication and write it down. This information is very important for your treatment.

Name Month/Year Tried

◆ Zoloft (Sertraline)
◆ Prozac (Fluoxetine)
◆ Celexa (Citalopram)
◆ Lexapro (Escitalopram)◆ Luvox (Fluvoxamine)
◆ Paxil (Paroxetine)
◆ Effexor (Venlafaxine)
◆ Pristiq
◆ Cymbalta (Duloxetine)◆ Remeron (Mirtazapine)
◆ Trintellix
◆ Viibryd
◆ Abilify
◆ Zyprexa (Olanzapine)◆ Seroquel (Quetiapine)
◆ Geodon (Ziprasidone)
◆ Risperidone
◆ Lithium
◆ Lamictal (Lamotrigine)
◆ Tegretol (Carbamazepine)

Name Month/Year

Dosage	**Maximum Dosage Tried**
50 mg/100 mg	
20 mg/40 mg	
20 mg/40 mg	
10 mg/20 mg	
25 mg/100 mg	
20 mg/30 mg	
37.5 mg/75 mg/ 150 mg	
50 mg/100 mg	
30 mg/60 mg	
15 mg/30 mg/ 45 mg	

10 mg/20 mg	
20 mg/40 mg	
2 mg/5 mg/10 mg	
10 mg/20 mg	
25 mg/50 mg/ 100 mg	
20 mg/40 mg/ 60 mg	
1 mg/2 mg/3 mg	
300 mg/600 mg	
25 mg/50 mg	
300 mg/600 mg	
Dosage	**Maximum Dosage**

		Tried	**Tried**
◆ Trileptal	**300 mg/600 mg**		
◆ Depakote (Valproic Acid)	**250 mg/500 mg**		
◆ Adderall	**10 mg/20 mg**		
◆ Concerta	**18mg/36 mg**		
◆ Vyvanse	**20 mg/50 mg**		
◆ Ritalin	**10 mg**		
◆ Ativan (Lorazepam)	**0.5 mg/1 mg**		
◆ Klonopin	**0.5 mg/1 mg**		

(Clonazepam)			
◆ Xanax (Alprazolam)	**0.25 mg**		
◆ Ambien (Zolpidem)	**5 mg/10 mg**		
◆ Wellbutrin (Bupropion)	**75 mg/150 mg**		
◆ Neurontin (Gabapentin)	**100 mg/300 mg**		

List all current medications with the dosage:

Medication	**Dosage**

Medi-Cal Disclosure Form

What is Medi-Cal?

The California Medical Assistance Program (Medi-Cal or MediCal) is California's Medicaid program serving low- income individuals, including families, seniors, persons with disabilities, children in foster care, pregnant women, and childless adults with incomes below 138% of federal poverty level.

Please read this disclosure very carefully before completing. This form is very important to the billing process for the mental health care services that you will receive.

You, as the patient, need to disclose to us if you currently have Medi-Cal or Medicaid services. If you currently do not but may become eligible any time in the future and plan to apply, you need to disclose it to office staff immediately. Failing to do so may result in your receiving unnecessary bills that you are not responsible for. Please initial in the appropriate spaces below.

_____ Yes, I have Medi-Cal

Medi-Cal Information: _____

_____ No, I do not have Medi-Cal

Print Name: _____ Date: _____

Signature: _____