HAROON SIDDIQUE, M.D., P.A.

902 PRESKITT RD, SUITE 200, DECATUR, TX 76234
3412 N. TARRANT PKWY SUITE 520 FORT WORTH, TX 76177
PHONE 940-626-1848 FAX 940-626-1849

Patient Name: (Last) _____ (First)_____ (MI) _____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Cell Phone Number: _____
Date of Birth: _____ Age: _____ Social Security: _____
Natural born Gender: [ ] M [ ] F Gender Preference:_____ Marital Status: _____
Preferred Pharmacy: _____ Pharmacy's Number: _____
Email Address (required for Patient Portal access):

EMPLOYMENT INFORMATION:
Patient Employer: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____
Zip: _____ Work Phone Number: _____ Ext: _____

RESPONSIBLE PARTY INFORMATION:
Responsible Party: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

PRIMARY INSURANCE COMPANY:
Name of Company: _____ Name of Insured: _____
Member ID#: _____ Group #: _____
Co-Pay Amount: _____ Effective Date: _____
Phone Number on the Back of Card (Provider Services): _____

SECONDARY INSURANCE COMPANY:
Name of Company: _____ Name of Insured: _____
Member ID#: _____ Group#: _____
Co-Pay Amount: _____ Effective Date: _____
Phone Number on the Back of Card (Provider Services): _____

EMERGENCY CONTACT INFORMATION:
Name: (Last) _____ (First) _____ Relation: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Name: (Last) _____ (First) _____ Relation: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

***Does Dr. Haroon Siddique's office have permission to release Health Information to those listed under EMERGENCY CONTACT INFORMATION. YES [ ] NO [ ]**

NAME (PRINT): _____

SIGNATURE: _____ **DATE:** _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, Haroon Siddique, M.D, P.A, to release/obtain and use the health information as described below. I understand that if the recipient authorized to receive the health information is not a health plan or health care provider, the released health information may no longer be protected by federal and state privacy regulations.

PATIENT NAME **DATE OF BIRTH** **SOCIAL SECURITY #**

Please list any caretakers, facilities, primary care physicians, referring physicians, counselors/therapists, family members, employers/disability companies, or any person with whom you would like us to be able to communicate with regarding your care and treatment with Dr. Siddique. Otherwise, we will not acknowledge any communication without your consent.

Authorized Information Released To and From: Wise Health System (WHS)

Primary Care Doctor: _____

Specialist Doctor: _____

Emergency Contact(s) name/number: _____

Organization (Disability, FMLA, Retirement. etc.): _____

PLEASE RELEASE THE FOLLOWING INFORMATION, INDICATED BY AN "X" OR INITIAL BELOW TO INDICATE ALL INFORMATION CAN BE RELEASED:

THIS INFORMATION IS NECESSARY FOR THE FOLLOWING PURPOSES:
• Follow-up Care • Patient is requesting disclosure • Disability Benefits • Attorney • Other _____

[ ] History & Physical [ ] Consultation [ ] Assessment [x] Lab Results [ ]Radiology Results [X] Medication

[ ] Psychotherapy Notes [x] Discharge Summary [x] Treatment Plan [ ] Other _____

[X] Psychiatric [X] Substance Abuse Records ***INITIALS*: _____**

The patient or the patient's representative must read the following statements: I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event, this consent shall expire in twelve (12) months from when it is signed unless otherwise specified. I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon expiration, Dr. Siddique can no longer use or disclose my information for the above purposes without a new authorization.

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipients(s) of that information.

I understand any of the above-requested information may include results of sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above-requested information may include results of alcohol/drug substance abuse and/or diagnosis and treatment of psychological disorders. I understand that I may see and obtain a copy of the information described on this form if I ask for it and that I get a copy of this form after I sign it.

TO THE PARTY RECEIVING THE INFORMATION: This information is being disclosed to you from records where confidentially may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without the written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

Signature Patient/Authorized Party **Date** **Relationship to Patient**

Patient Name:_____ **DOB:** _____

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Acknowledgment Agreement for Treatment with Schedule II-IV Medication(s)

I agree to take controlled (Schedule II-IV) medication(s) as prescribed by Dr. Siddique MD. PA. I will inform the physicians if there are any changes in my medication that are prescribed by other physicians. I understand that I will no longer be a patient of Dr. Siddique's private practice if I don't follow his directions.

I acknowledge that the schedule II-IV medication(s) being prescribed have an addiction and abuse potential. As such they are highly controlled and close monitoring is needed. Please note that early refills are not allowed.

In the case of lost or stolen medication, it would be best to file a police report in order to document the event. Depending on the circumstance, you may be required to provide a copy of the report prior to obtaining an early refill.

I acknowledge that I may be subject to regular drug screenings. I acknowledge that a failed drug screen or drug screen not positive for prescribed substances may result in discontinuation of prescribed medication and/or discharge from the private practice.

_____ _____

Patient's Signature **Date**

Haroon Siddique, M.D., P.A.

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Telemedicine Consent Form

I understand there are potential risks with this technology:

1. The video connection may not work or that it may stop working during the consultation.
2. The video picture or information transmitted may not be clear enough to be useful for the consultation.
3. I may be required to go to the location of the consulting physician if it is felt that the information obtained via telemedicine was not sufficient to make a diagnosis.

The benefits of a telemedicine consultation are:

1. You may not need to travel to the consult location.
2. You have access to a specialist through this consultation.

I give my consent to be interviewed by the consulting health care provider. I also understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.

I understand that a limited physical examination will take place during the videoconference and that I have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the counseling health care provider.

I understand the financial responsibility. In consideration for the telehealth services rendered to me, I agree to pay the charges not covered by any insurer or third-party payer, including any deductible, or co-payment, or any charges not covered as a result of my failure to provide notification or obtain pre-authorization for treatment as required by any insurer or third party pay to Haroon Siddique, M.D., P.A. Should my account be referred to collection, I agree to pay Haroon Siddique, M.D., P.A. reasonable attorney fees and collection expenses.

I authorize the release of any relevant medical information about me to the consulting health care provider, any staff the consulting health care provider supervises, third party payers and other healthcare providers who may need this information for continuing care purposes

I hereby release Haroon Siddique, M.D., P.A., it's personnel and any other person participating in my care from any and all liability which may arise from the taking and authorized use of such videotapes, digital recording films, and photographs.

I have read this document in its entirety and understand the risk and benefits of the telemedicine consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the conditions described in this document.

Patient's Name (Print)	**Date of Birth**
Patient's Signature	**Date**

Patient Name: _____ **DOB:** _____

Family History

List all FAMILY HISTORY of major illnesses including psychiatric, neurologic, alcoholism, drug abuse, suicide, and suicide attempts:

_____

_____

	Father □ Alive □ Deceased	Mother □ Alive □ Deceased	Father's Parents □ Alive □ Deceased	Mother's Parents □ Alive □ Deceased	Siblings How many?	Children
Diabetes						
High Blood Pressure						
Heart Disease						
Stroke						
Mental Illness						
Cancer						
Autoimmune Disease(s)						

How many children do you have? _____

Personal Medical History

Cancer [ ] _____
Diabetes Mellitus [ ] _____
Thyroid Problems [ ] _____
Heart Problems [ ] _____
Blood Pressure Problems [ ] _____
Seizures [ ] _____
Others [ ] _____

_____

Do you smoke Cigarettes? YES [ ] NO [ ]

MEDICATION ALLERGIES: _____

_____

Please list previous surgeries: _____

_____

_____

_____

Patient Name: _____ **DOB:** _____

Previous Mental Health Treatment

Have you ever been hospitalized for a mental illness? Yes [ ] No [ ]

If yes, please list below any or all diagnosis given, as well as, date(s) of admission, the name of the hospital: _____

_____

Date(s): _____ Hospital: _____

Outpatient Program: Yes [ ] No [ ] _____

Previous / Current Psychiatrist: _____

Have you ever been hospitalized substance abuse? Yes [ ] No [ ]

If yes, what substance? _____

Attended NA / AA: _____

List any psychiatric medication you have taken in the past: _____

_____

Medications

Do you take medications as prescribed by your physician(s)? Yes [ ] No [ ]

Please list below any and all medications you are currently taking, including the name of the medication, dosage, frequency, and prescribing doctor.

(Example: Seroquel 300mg, 1 tablet, Twice a day, Dr. Siddique)

Name of Medication	Dosage	Frequency	Doctor

Patient Name: _____ DOB: _____

THE MOOD DISORDER QUESTIONNAIRE

1. Has there ever been a period, of time when you were not your usual self and: YES NO

- You felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?.....[ ] [ ]
- Did you feel much more self-confident than usual? ..... [ ] [ ]
- You were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night? ..... [ ] [ ]
- Were you much more interested in sex than usual? ..... [ ] [ ]
- You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? ..... [ ] [ ]
- Spending money got you or your family into trouble? ..... [ ] [ ]
- You were so easily distracted by things around you that you had trouble concentrating or staying on track? ..... [ ] [ ]
- You were so irritable that you shouted at people or started fights or arguments?..... [ ] [ ]
- You got much less sleep than usual and found you did not miss it?..... [ ] [ ]
- You were much more talkative or spoke much faster than usual?..... [ ] [ ]
- Thoughts raced through your head, or you could not slow your mind down? ..... [ ] [ ]
- You had much more energy than usual? ..... [ ] [ ]
- You were much more active or did many more things than usual? ..... [ ] [ ]

2. If you checked YES to more than one of the above, have several of these happened during the same period?..... [ ] [ ]

3. How much of a problem did any of this cause you—like being unable to work, having family, money, or legal troubles, getting into arguments or fights?

[ ] No Problem [ ] Minor Problem [ ] Moderate Problem [ ] Serious Problem

4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had a manic-depressive illness or bipolar disorder? ..... [ ] [ ]

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? ..... [ ] [ ]

_____ _____

Patients Signature **Date**

Patient Name: _____ **DOB:** _____

Over the last two weeks or more, have you noticed the following (for each line, check the box that best applies to you?

	Not at All	Several Days	More Than Half the Days	Nearly Everyday
1. Nothing seems to give me much pleasure				
2. **Feeling down, depressed, or hopeless**				
3. I feel tired; have no energy				
4. **I cannot concentrate or focus**				
5. I have difficulty sleeping				
6. **I sleep too much**				
7. I have lost some appetite				
8. **I am eating more**				
9. I feel Guilt or worthlessness				
10. **I feel overwhelmed or helpless**				
11. I feel like a failure or that I've let myself or my family down.				
12. **I have thoughts of suicide**				
13. I feel tense, anxious, or can't sit still				
14. **I feel worried or fearful**				
15. I worry about dying or losing control				
16. **I get anxious thinking about upcoming events or situations**				
17. I am nervous in a social situation				
18. **I avoid places that remind me of a bad experience**				
19. **I cannot get certain thoughts out of my mind**				
20. I feel I must repeat certain acts or rituals				
21. **I feel the need to check and recheck things**				
Have you ever noticed the following?				
22. **I have more energy than usual**				
23. I have felt unusually irritable or angry				
24. **I have felt unusually excited, revved up, or high**				
Indicate whether any of the above symptoms:	**Not at All**	**Several Days**	**More Than Half the Days**	**Nearly Everyday**
25. Interfere with work or school				
26. **Affects my relationships with friends or family**				
27. Has led to my using alcohol to get by				
28. **Has led to my using other substances**				

How often do you have a drink containing alcohol? What type? Beer [ ] Wine [ ] Liquor [ ]	Never	Monthly or less	2-4 times/ month	2-3 times/ week	4 or more times/ week	Daily
How many alcoholic drinks do you have on a typical day when you are drinking?	Never	1 to 2	3 to 4	5 to 6	7,8, or 9	10 or more
How often do you have six or more drinks on one occasion?	Never		Less than monthly	Monthly	Weekly	Daily or almost daily

Patient Name: _____ **DOB:** _____

Please state the principal reason you are requesting a consultation or treatment:

Please describe your illness from the time of onset of your symptoms to the present. Provide as many dates, names, and addresses of your psychiatrist, psychologists, and/or social workers who have treated you as you can. Also, provide the kinds of treatment you have received, including names of medication and your response to them.

Patient Name: _____ DOB:_____ DATE:_____

Adult ADHD symptom checklist (ASRS v1.1)

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.	NEVER	RARELY	SOMETIMES	OFTEN	VERY OFTEN
PART A					
How often do you have trouble wrapping up the final details of a project once the challenging parts have been completed?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART B					
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or in other situations in which you are expected to stay seated?					
How often do you feel restless or fidgety?					
How often do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish it themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					

How old were you when these symptoms first began to occur? _____

Patient Name: _____ **DOB:** _____

HAROON SIDDIQUE, M.D., P.A.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT FORM

Your signature below indicates that you have been offered a copy of HAROON SIDDIQUE, M.D., P.A.'s Notice of Privacy Practices and Patient's Rights and Responsibility. If you have any questions about the Notice of Privacy Practices and Patient's Rights and Responsibility, please call HAROON SIDDIQUE, M.D., P.A. Privacy Officer at 940-626-1848.

I acknowledge that Haroon Siddique, M.D., P.A., has provided me with a written copy of their Notice of Privacy Practices. _____ **(Initial)**

I also acknowledge that I have been given the opportunity to read the Notice of Privacy Practices and ask questions. _____ **(Initial)**

I acknowledge that Haroon Siddique, M.D., P.A., will disclose my Protected Health Information to a family member, other relatives, close friend, or any other person I identify that directly relates to that person's involvement in my care. _____ **(Initial)**

I acknowledge that Haroon Siddique, M.D., P.A., may communicate with me via US mail, home phone number, or cell phone number. _____ **(Initial)**

I have been offered the Notice of Privacy Practices and Patient's Rights and Responsibility.
Copy can be mailed/emailed upon request

HIPAA EXCEPTIONS:

PLEASE CHECK YES OR NO

YES [ ] NO [ ] OK to have a message left on my answering machine.

YES [ ] NO [ ] OK to leave a message with my spouse.

YES [ ] NO [ ] OK to leave a message with any adult who answers my phone.

YES [ ] NO [ ] OK to send a consultation report to my primary care physician.

PRINT PATIENT NAME _____ DATE _____

PATIENT SIGNATURE _____ DATE _____

PRINT LEGAL GUARDIAN OR PATIENT REPRESNTATIVE _____ DATE _____

LEGAL GUARDIAN OR PATIENT REPRESENTATIVE SIGNATURE _____ DATE _____

Patient Name: _____ **DOB:** _____

HAROON SIDDIQUE, M.D., P.A.

PATIENT REGISTRATION AND CONSENT FOR TREATMENT

This consent applies to a variety of patient situations. Due to practical limitations, alterations are not accepted. If you have any questions regarding this consent form, office management will be happy to assist you.

I. CONSENT FOR TREATMENT:

I, _____, am presenting myself to **Haroon Siddique, M.D., P.A.** for evaluation, diagnosis and/or treatment of my medical condition. I give consent and authorize my physician(s) or his designees to perform and/or perform all exams, test, procedure and any other deemed necessary or advisable for the evaluation, diagnosis, and treatment of my medical condition. This consent is valid for each visit I make to **Haroon Siddique, M.D., P.A.,** unless and until revoked by me in writing. I acknowledge that **Haroon Siddique, M.D., P.A.** is committed to protecting the confidentiality of my medical record information in accordance with applicable laws and regulations. However, in order to provide treatment to me and to conduct billing and other health care operation activities, **Haroon Siddique, M.D., P.A.** requires permission to disclose my medical records to certain individuals and entities. Therefore, I give Consent and authorize **Haroon Siddique, M.A., P.A.** to disclose any of all of my medical record information, including but not limited to treatment information, insurance, and other financial information and information about communicable diseases such as human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS), alcohol and substance abuse, mental health diagnosis and treatment, and laboratory test results ("Medical Records"), to the following individuals and entities:

- Physicians and other health care personnel who are involved in providing or managing my health care. Disclosure to these individuals occurs through the sharing of paper medical records and through access to electronic systems
- My health insurance plan, Medicaid, Medicare, or any other person or entity that may be responsible for paying or processing payment for my medical treatment.
- Employees, agents, representatives, volunteers or contractors of **Haroon Siddique, M.D., P.A.** for the purpose of conducting health care activities including but not limited to administration, billing, compliance, quality assurance, risk management, credentialing and any other appropriate health care facility activities or operation:
- Any person or entity to whom I give written authorization to may receive Medical Records on a form provided by **Haroon Siddique, M.D., P.A**., or such other format acceptable to **Haroon Siddique, M.D., P.A**
- Any other person or entity that is required by law to have access to my Medical Records. I understand that the disclosure of my Medical Records may be necessary before my insurer will pay for the cost of my medical treatment. I agree not to hold **Haroon Siddique, M.D., P.A**, its agents, or employees liable for any damages as a result of disclosing my Medical Records in accordance with this consent.

II. ASSIGNMENT OF BENEFITS/CAUSES OF ACTION: In consideration of services to be rendered to the patient, I assign my transfer to **Haroon Siddique, M.D., P.A**., up to the amount of my total financial obligation to **Haroon Siddique, M.D., P.A.,** all rights, title and interest in benefits payable out of any third-party action, or out of recovery under the uninsured motorist provisions or out of the medical payment provisions of any automobile insurance policy(ies), or out of any other insurance proceeds that I am entitled to recover. I further authorize **Haroon Siddique, M.D., P.A**. to pursue on my behalf any claim I may be entitled to pursue before the Crimes Victims Compensation Division of the Texas Industrial Accident Board in the event my treatment is necessitated by injuries received as the result of a violent crime, but in no event shall this be construed to be an obligation of **Haroon Siddique, M.D., P.A.** I understand that this agreement in no way restricts me or my dependents' rights to pursue any such claim before the Crimes Compensation Division of the Texas Industrial Accident Board.

III. FINANCIAL RESPONSIBILITY: In consideration of services rendered or to be rendered to the patient, I accept financial responsibility and agree to pay for all charges and expenses incurred or to be incurred. I further understand that payment is due upon request. Unless **Haroon Siddique, M.D., P.A.** has a contract with my insurance carrier that states otherwise**, I am responsible for my remaining balance after reasonable collection efforts have been pursued with my insurance company.** If my account becomes delinquent and it is necessary for my account to be referred to attorneys or collection agencies, I will pay all charges that are my obligation, reasonable attorney's fees, and other collection expenses.

Patient Name: _____ **DOB:** _____

IV. FEDERAL AND STATE PROGRAMS: If I am eligible for health care benefits under any federal or state program, including but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs, including Title XVIII and XIX of the Social Security Act, is correct. I authorize any holder of medical or other information about me to the Social Security Administration or intermediaries or carrier any information needed for any federal or state program related claims; I request that payment of authorized benefits be made to **Haroon Siddique, M.D., P.A.** on my behalf. I understand that I am responsible for all applicable health insurance deductible and co-insurance amounts under these programs.

V. ACCIDENTAL EXPOSURE OF HEALTH CARE WORKERS: I understand that Texas Law provides, and I give consent, that I may be tested for possible exposure to certain communicable diseases, including but not limited to the human immunodeficiency virus (HIV), the virus associated with AIDS, hepatitis B, and C, and syphilis, Such testing will be conducted pursuant to applicable laws and can include but is not limited to the following situation, if a health care worker is exposed to my blood or other bodily fluid.

VI. PRACTICE POLICIES: By signing the Patient Registration and Consent for Treatment form (Consent), I acknowledge that I have been offered a copy of the practice policies of **Haroon Siddique, M.D., P.A.**

VII. EFFECT OF CONSENT: By signing the Patient Registration and Consent for Treatment form (Consent), I acknowledge that I have read and understood the information contained in this Consent. I accept the terms of this Consent, either on behalf of myself as the patient or on behalf of the patient as an authorized legal representative of the patient.

I acknowledge that I have read and understood the information as stated above for the following categories. (Please initial next to each statement.)

I.	**CONSENT FOR TREATMENT**	_____ **(Initial)**
II.	**ASSIGNMENT OF BENEFITS/CAUSES OF ACTIO**	_____ **(Initial)**
III.	**FINANCIAL RESPONSIBILITY**	_____ **(Initial)**
IV.	**FEDERAL AND STATE PROGRAMS**	_____ **(Initial)**
V.	**ACCIDENTAL EXPOSURE OF HEALTH CARE WORKERS**	_____ **(Initial)**
VI.	**PRACTICE POLICIES**	_____ **(Initial)**
VII.	**EFFECT OF CONSENT**	_____ **(Initial)**

This Consent supersedes all prior consents or other authorization forms signed by me pertaining to issues discussed at this moment. I acknowledge that signing the Consent is a condition of treatment by **Haroon Siddique, M.D., P.A.,** and alteration of any/or refusal to sign this form will result in denial of treatment. I understand that I may revoke this Consent at any time, except to the extent that **Haroon Siddique, M.D., P.A**. has initiated actions based on the form. Any revocation of the Consent may result in termination of patient care in accordance with the state law. If signing as the legal representative, I represent to **Haroon Siddique, M.D., P.A.** that I am the legal representative of the patient. Should my legal authority terminate, I agree to provide written notification to **Haroon Siddique, M.D., P.A.**

Patient's Printed Name	**Patient's Signature**	**Date**
Legal Representative's Name	**Legal Representative's Signature**	**Date**

Haroon Siddique, M.D., P.A.

PATIENT'S RIGHTS AND RESPONSIBILITIES:

The care a patient receives depends partially on the patient him/herself. Therefore, in addition to the rights below, a patient has certain rights and responsibilities.

- Patients have the right to be treated with consideration, respect, and recognition of their individuality, including the need for privacy in their treatment.
- Patients have the right to be informed of his/her health status in terms that patient can reasonably be expected to understand, and to participate in the development and the implementation of his/her plan of care and treatment.
- Patients have the right to receive ethical, high-quality, safe, and professional care without discrimination regardless of their race, religion, color, national origin, sex, age, sexual orientation or disability, or the way in which their care is paid.
- Patients have the right to have his/her private medical records, including all computerized medical information, kept confidential except to those on the release form. The patient may decide who may receive copies of the records, except when required by law. Please note, there is a **$35 fee that comes with the release of records**. Record request will be completed within a 72-hour time frame.
- Patients have the right to examine and receive an explanation of the patient's healthcare facility's bill regardless of the source of payment, and may receive upon request, information relating to the availability of known financial resources.
- Patients have the right to have medical forms filled out by the physician, such as short-term disability paperwork, etc. A **$35 processing fee** will be required at the time of request.
- To provide accurate and complete information concerning his/her health status, medical history, hospitalizations, medications, and other matters related to his/her health. The patient should also inform/address any health care concerns with their health care provider or nurse regarding changes in their condition or symptoms.
- To report perceived risks in his/her care and unexpected changes in his/her condition to the responsible practitioner and nurses.
- To follow the plan of care established by his/her physician.
- To be responsible for his/her actions; should he/she refuse treatment or not follow his/her physician's orders.
- To assure that the financial obligations of his/her healthcare care are fulfilled as promptly as possible, including account, balances accumulated from Dr. Siddique's Wise Health Systems affiliated services like Intensive Outpatient Program (IOP), hospital consultations, or Wise Health Systems Behavioral Unit.
- To be considerate of the rights of other patients and facility personnel. Please note, we do not allow active cell phone calls in office out of courtesy of other patients.
- Patient must keep their appointments or cancel it 24 hours in advance to avoid a **$35 cancellation fee.** Exceptions for emergencies apply. **(Please note - medications will not be refilled without an appointment.) It is patient responsibility to contact the office within a reasonable time frame if you are late to avoid being rescheduled.**
- Any patient that accumulates 3 no-show appointments within a calendar year will be discharged from care. Cancelling an appointment without 24 hours' notice is considered a no-show visit.
- Patients who are not seen within a 1-2-month time frame of their recommended follow-up date will be discharge from care. It is important to keep your follow-up appointments as the continuation of treatment is a vital aspect of your mental health.
- Patient is responsible to bring a written, **updated** list of all medications to each appointment.

Patient's Name (Print)	**Date of Birth**
Patient's Signature	**Date**