M. N. Shamsi PC
1000 Germantown Pike
Unit H-4
Plymouth Meeting, PA 19462

Informed Consent for Telemedicine/Telehealth Services

Patient Name _____ Date of birth _____

Location of patient_____

Physician/therapist name _____ Location _____

Consultant name _____ Location _____

Introduction:

Telemedicine/telehealth involves the use of electronic communication to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Laboratory tests
- Live two-way audio and video

Expected benefits:

- Improved access to medical care, psychiatric services, psychotherapy, and/or counseling.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine/telehealth services. These risks include, but may not be limited to:

- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Please initial after reading this page: _____

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine/telehealth services, and that no information obtained in the use of telemedicine/telehealth services which identifies me will disclosed to other entities without my consent.
2. I understand that I have the rights to withhold or withdraw my consent to the use of telemedicine/telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine/telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical/health care may be available to me, and that I may choose one or more of these at any time. My doctor/therapist has explained the alternatives to my satisfaction.
5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
6. I understand that insurance coverage of telehealth sessions may differ based on my insurance plan. It is in my best interest to check with my insurance company regarding the coverage.
7. I understand that I am fully responsible for co-payments and deductible amounts, and that I am fully responsible to pay the provider if telehealth/telemedicine sessions are not covered by my insurance company.

Patient Consent to the Use of Telehealth/Telemedicine Services

I have read and understand the information provided above regarding telehealth/telemedicine services, have discussed it with my physician/therapist, and all of my questions have been answered to my satisfaction. I hereby give consent for the use of telehealth/telemedicine services in my care.

I hereby authorize Muhammad Nadeem Shamsi P.C. to use telehealth/telemedicine services in the course of my diagnosis and treatment.

Signature of patient (or person authorized to sign for the patient):

_____ *Date:* _____

If authorized signer, relationship to patient: _____

Witness _____ *Date* _____

I have been offered a copy of this consent form (patient's initials): _____

M. Nadeem Shamsi, P.C.
1000 Germantown Pike, Suit H-4, Plymouth Meeting, PA 19462

REGISTRATION FORM
(Please Print)

Today's Date:			**Primary Care Provider:**		
PATIENT INFORMATION					
Patient's Last name: **First:** **Middle:**			**□ Mr. □ Mrs.** **□ Miss □ Ms.**	**Marital status: □ Single □ Mar □ Div □ Sep □ Wid**	
Social Security #:	**Maiden name:**	**Birth date:**	**Age:**	**Sex: □ M □ F**	
Street Address:	**P.O. box:**	**City & State:**	**ZIP Code:**		
Home Phone #:	**Alternate phone #:**	**Emergency contact:**	**Emergency contact #:**		
Occupation:	**Employer:**	**Employer phone #:**			
Referral Source:		**Email:**			

INSURANCE INFORMATION
(Please give your insurance card to the receptionist)

Person responsible for bill:	**Birth date:**	**Address (if different):**	**Home phone #:**		
Occupation:	**Employer:**	**Employer address:**	**Employer phone #:**		
Is this patient covered by insurance? □ Yes □ No					
Please indicate primary insurance:					
Subscriber's Name:	**Subscriber's S.S. no:**	**Birth date:**	**Group no.:**	**Policy no.:**	**Co-payment: $**
Patient's relationship to subscriber:	**□ Self**	**□ Spouse**	**□ Child**	**□ Other**	
Name of secondary (if applicable):	**Subscriber's name:**	**Group #:**	**Policy #:**		
Patient's relationship to subscriber:	**□ Self**	**□ Spouse**	**□ Child**	**□ Other**	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Shamsi or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

M. N. Shamsi PC

1000 Germantown Pike
Unit H-4
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In an effort to ensure our patients are compliant with their treatment plan, we have instituted a policy of drug testing in accordance with the most recent medical literature on this subject. All patients receiving prescriptions will be subject to random drug screening. Failure or refusal to produce a sample at the time requested will disqualify you from receiving further prescriptions from this practice. We send all of our samples to a certified laboratory for confirmation. If results are inconsistent with your treatment plan at any time, we reserve the right to discontinue treatment. It is your responsibility to take your medications as prescribed. Inconsistent results include the presence of illicit substances, the presence of medications not prescribed to you or the absence of medications prescribed. Do not try to manipulate the test. Current drug testing methods are very sophisticated and measure the prescribed medications as well as metabolites. The laboratory will be able to differentiate between samples that are consistent with treatment plans and samples that have been tampered with. Any confusing results will be interpreted as inconsistent. If you are taking your medication as prescribed, there should not be any confusion in the results.

We understand there is a cost associated with testing. Unfortunately this is now a necessary part of therapy. While most insurance plans cover much of the cost of testing, it is your responsibility to pay the costs not covered by insurance.

We understand that some of our patients are elderly or incapacitated and obtaining a sample can be inconvenient. Unfortunately, we cannot and do not discriminate on the basis of age, sex, race, nationality, religious or sexual orientation and all patients will be subject to this policy. The intent of this policy is to protect the patient, the physician, the therapy and society.

Remember the use of these potent prescriptions is a privilege. As a patient it is your responsibility to use your medication as prescribed. It is unlawful to sell or give your medication away. It is your responsibility to keep your medicine secured and away from children or others who may misuse or divert it. This policy may be amended in accordance with new medical findings or legislature mandates.

The following are a few terms that you should be familiar with that will cause you to be disqualified from receiving prescriptions from this practice.

Abuse - The willful misuse of medications, for example, to get high.
Overuse - Taking more medication than prescribed.
Diversion - Unlawful channeling of regulated pharmaceuticals from legal sources to the illicit market.
Illicit - Not legal or lawful; illegal

Patient Signature: _____ Date: _____

Print Name: _____

M. Nadeem Shamsi, P.C.

1000 Germantown Pike, Suit H-4, Plymouth Meeting, PA 19462

Phone 610-275-0345 Fax 610-275-0346

INFORMED CONSENT FOR MEDICATION

Name: _____Date: _____ MR#_____

Your psychiatrist has recommended the use of medication to address your mental health symptoms. Please read the following statement. Your signature below indicates that you have read the following and have had the opportunity to discuss your concerns or questions with your psychiatrist.

1. I have been educated about the prescribed medication. I have been informed of the advantages, disadvantages, side effects and alternatives to this medication. I understand that taking this medication is strictly voluntary.

2. I have had the opportunity to discuss the proposed treatment with my psychiatrist and have had the opportunity to have any questions answered to my satisfaction.

3. I understand that my psychiatrist believes that this medication is likely to help me, but is unable to give a guarantee of its effectiveness.

4. I understand that all medicine come with a risk of side effects and some side effects are rare, unpredictable and potentially harmful or deadly.

5. I understand that medicines can have an adverse effect on pregnancy and that all efforts should be made to avoid pregnancy during medication treatment. Should l become pregnant while on medicine, I understand I must contact my psychiatrist immediately to discuss the potential risks to myself, the pregnancy and the baby. I also understand that obstetricians should be informed that you have been on medications

6. I understand that I should inform the doctor or contact the office staff if there are any problems, reactions, and /or changes in my condition which may be related to this medication.

7. I understand that any written patient information available through this office is selective for its use as an educational aid and does not cover all the possible uses, actions, precautions, side effects, or interactions with this medication. It is not intended as medical advice for individual problems.

8. Some medications require periodic lab work to monitor blood levels or / to screen for possible negative effects on major organ systems of the body. Once ordered it is my responsibility to follow through on getting the ordered blood work complete. Failure to do so could potentially put me at risk for harm.

9. I understand that this consent allows other psychiatrist working in coordination with Dr. Shamsi to prescribe medications as clinically indicates if Dr. Shamsi is not available.

_____ _____

Psychiatrist Signature _____ Patient and/or Parent Signature for minor.

Informed Consent to treatment

I have voluntarily chosen to receive treatment with Dr. Shamsi or contractors (Provider), in a good therapeutic relationship. It is considered my right as well my duty to ask any questions and fully discuss the risks and benefits of any proposed treatment. It should also include the risks & benefits of any alternate treatment/or no treatment.

Pt/REP Signature:_____ Date: _____

Pt Name: _____

Acceptance of Financial Responsibility:

I take full responsibility of the financial liability for the proposed services provided. I understand that the time is reserved in advance. If I don't give at least 24-48 hours notice to cancel, I may be charged $70-$150. I'm responsible for co-pay, coinsurance, deductible, & non-covered services. There is a $5 charge for late payment of co pay. We charged $30 for any bounced bank check. I allow Dr. Shamsi and his associates to bill my insurance company.

Pt/REP Signature:_____ Date: _____

Pt Name: _____

Medical Records Release etc.

I understand that the confidentiality of my records is protected, and release of information will be only by my written consent. Exceptions to confidentiality are as follows: a) local and state law may require reports of cases of child/minor/elderly abuse or neglect; b) if there is danger to self or others. C) Court order.

I understand that all records pertaining to my treatment may be released to my insurance company for claim processing, utilization review purposes, quality management or grievance/appeal process etc.

Pt Signature:_____ Date: _____

Pt Name: _____

Guardian's Signature: _____ Date _____
Guardian's Name: _____

M. N. Shamsi PC

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DUE TO THE NEW FEDERAL PATIENT CONFIDENTIALITY LAWS (HIPAA) OUR OFFICE WILL NEED YOUR PERMISSION TO DO THE FOLLOWING: CIRCLE ONE AND THEN INITIAL.

CONFIRM APPOINTMENTS	**YES ____**	**NO ____**
LEAVE MESSAGES WITH ANYONE OR ON RECORDER	**YES ____**	**NO ____**
LEAVE LAB RESULTS WITH ANYONE OR ON RECORDER	**YES ____**	**NO ____**

BY SIGNING THE ABOVE I FULLY UNDERSTAND THAT I AM GIVING DR. SHAMSI AND ASSOCIATES, PERMISSION TO DO THE ABOVE.

_____ **DATE**

_____ **PATIENT NAME**

_____ **GUARDIAN SIGN**

_____ **PATIENT SIGNATURE**

_____ **STAFF WITNESS**

M. N. Shamsi PC

1000 Germantown Pike
Unit H-4
Plymouth Meeting, PA 19462

Authorization to disclose or obtain confidential client information

I hereby authorize MUHAMMAD NADEEM SHAMSI P.C. to disclose / obtain protected medical information as described below from the records of:

Patient's Last Name: _____ First: _____ M. Initial: _____

Address: _____

Date of birth: _____Telephone Number:_____

To be disclosed to/obtain from: Name: _____

(Person/organization disclosure is being made to/obtained from)

Address: _____ Telephone#_____

Fax #: _____

Reason for Disclosure/Obtaining Information: _____***Coordination of care*** _____

I understand that:

- This authorization may be revoked at any time by writing, except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization revoking it will only prevent further disclosure.
- Information (except drug and alcohol information) disclosure pursuant to this authorization may be subject to re- disclosure by the individual /organization identified
- MUHAMMAD NADEEM SHAMSI P.C. and its designee are hereby released from any legal responsibility or liability for disclosure of the specified information.
- The Authorization may include Mental Health, Drug & Alcohol Abuse and or HIV related information.

The information to be disclosed:

*****Check in box next to information you wish to have disclosed.

Financial Information		Medication Information	
Medical Diagnosis/treatment		Mental Health Diagnosis	
Laboratory Record		Progress Notes/Treatment Plans	
Psychiatric Evaluation		Psychotherapy notes	

(Two years from today.)

Authorization: Start Date _____ End Date _____

Signature of Client/Personal Representative: _____ Date_____

Guardian Signature _____ Date_____

Signature of Witness _____ Date_____

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

M. N. Shamsi PC
1000 Germantown Pike
Unit H-4
Plymouth Meeting, PA 19462

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing,. a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) - Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information - This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the Specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications - You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information - If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures - You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach - We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

M. N. Shamsi PC
1000 Germantown Pike
Unit H-4
Plymouth Meeting, PA 19462

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of M. N. SHAMSI, P.C. Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____	_____
Patient Name (Type or Print)	Patient's Date of Birth
_____	_____
Signature of Patient or Parent/Legal Guardian	Date

M. N. Shamsi PC
1000 Germantown Pike
Unit H-4
Plymouth Meeting, PA 19462

Credit Card Pre-Authorization Form

I authorize Muhammad Nadeem Shamsi, P.C to keep my signature on file and to charge the credit card selected below for the following:

- ❑ **Balance remaining after claim (s) is (are) resolved not to exceed $ _____for:**
  - ❑ This consultation only
  - ❑ All consultations this calendar year
  - ❑ All consultations from_____ to _____
    (date) (date)
- ❑ **Recurring charges of $_____ to be charged every _____**
  (frequency)
  - ❑ From _____to _____
    (date) (date)
- ❑ **Charges for the following family members:**

_____ _____
(authorized family member) (authorized family member)

_____ _____
(authorized family member) (authorized family member)

Check One:

- ❑ Visa®
- ❑ MasterCard®
- ❑ American Express®
- ❑ Discover Card®

Patient Name:_____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State:_____ Zip: _____

Credit Card Number: _____ Exp. Date: _____

Cardholder Signature: _____ **Date:** _____