DR SHARAD B. KULKARNI, M.D., P.A.
CHILD, ADOLESCENT, AND ADULT PSYCHIATRY
1802 SNAKE RIVER RD. SUITE C, KATY, TX 77449
PHN: 281-829-3332 FAX: 281-829-3342

PATIENT REGISTRATION FORM:

NAME:_____

DATE OF BIRTH:_____ AGE:_____ SOCIAL SECURITY:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

_____MALE _____FEMALE MARITAL STATUS:_____

HOME #(_____)_____ CELL #(_____)_____

EMPLOYER:_____ WORK #(_____)_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

OTHER INFORMATION:

SPOUSE, DAD/MOM,_____ DATE OF BIRTH_____

SOCIAL SECURITY # _____ WORK/CELL #(_____)_____

INSURANCE COMPANY:_____PHONE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

NAME OF INSURED:_____ DATE OF DATE: _____

POLICY/ID#_____ GROUP #_____

SOCIAL SECURITY #:_____

SECONDARY INSURANCE COMPANY:_____

NAME OF INSURED:_____ DATE OF BIRTH:_____

POLICY/ID#_____ GROUP #_____

SIGNATURE OF PATIENT/ PARENT/ GUARDIAN

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MEDICAL HISTORY:

REASON FOR VISIT:_____

_____

SURGICAL HISTORY: _____

FAMILY HISTORY (MEDICAL):

_____

_____

FAMILY HISTORY (BEHAVIORAL): _____

_____

PLEASE PROVIDE THE NAME AND PHONE NUMBER OF YOUR PREVIOUS BEHAVIORAL HEALTH PROVIDER.

_____

_____

PLEASE PROVIDE US WITH A COPY OF YOUR MOST RECENT LAB RESULTS AND PHARMACY RECORDS FROM AT LEAST THE PAST TWELVE MONTHS. THIS IS **REQUIRED** PRIOR TO YOUR VISIT WITH DR. KULKARNI.

SITUATIONAL CHANGES: 3 WISHES

1._____
2._____
3._____

SIGNATURE:_____ DATE:_____

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RELEASE OF INFORMATION/AUTHORIZATION FORM

NAME OF PATIENT:_____ TODAY'S DATE_____
PERSON SIGNING RELEASE:_____
RELATIONSHIP TO PATIENT:_____

PLEASE INITIAL THE FOLLOWING TO ACKNOWLEDGE YOUR UNDERSTANDING:
_____ I AUTHORIZE THE RELEASE OF ANY MEDICAL AND/OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM.

_____ I DO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES.

_____I UNDERSTAND THAT DISCLOSURE OF MY RECORDS CAN BE MADE WITHOUT MY WRITTEN CONSENT TO THE STATE AND/OR FEDERAL COURT, IF SUBPOENAED.

IF PATIENT IS A MINOR:
I,_____ (PARENT/GUARDIAN), DO GIVE THE CONSENT FOR THE ASSESSMENT AND/OR CLINICAL TREATMENT OF, _____, A MINOR CHILD. MY SIGNATURE, HEREIN, REPRESENTS MY LEGAL AUTHORITY TO PROVIDE CONSENT FOR THE AFOREMENTIONED MINOR. _____ (PLEASE SIGN HERE)

IN ORDER TO CONFIRM/SCHEDULE APPOINTMENT, I REQUEST THAT I BE CONTACTED VIA THE FOLLOWING MEANS OF COMMUNICATION:
HOME(_____)_____ CELL(_____)_____ WORK(_____)_____

I, _____, AFFIRM THAT MY SIGNATURE BELOW INDICATES MY UNDERSTANDING OF THE POLICIES REGARDING RELEASE OF INFORMATION/AUTHORIZATION.

SIGNATURE:_____ DATE:_____

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CONSENT FOR TREATMENT:

I, (PARENT/ LEGAL GUARDIAN/SELF), _____HAVE BEEN INFORMED BY DR. SHARAD B. KULKARNI MD PA THAT I AM IN NEED OF PSYCHOTROPIC MEDICATION AND/OR PSYCHOTHERAPY, INDIVIDUAL/MARITAL/GROUP OR CHEMICAL DEPENDENCY COUNSELING, FOR TREATMENT OF MY ILLNESS. DR. KULKARNI HAS EXPLAINED TO ME THE BENEFITS, RISKS AND ALTERNATIVES OF THE USE TO THE MEDICATIONS OFFERED. I UNDERSTAND THAT DR. KULKARNI OFFERS ONLY SUPPORTIVE THERAPY. EXTENSIVE THERAPY HAS TO BE OBTAINED FROM A LICENSED PROFESSIONAL COUNSELOR. I FULLY UNDERSTAND THAT THE TREATMENT DR. KULKARNI HAS ADVISED WILL BE BENEFICIAL TO ME, AND THERE IS NO GUARANTEE AS TO THE RESULTS THAT MAY BE EXPECTED. ON THIS PREMISE, I AUTHORIZE DR. SHARAD B KULKARNI, MD PA, TO RENDER THE NECESSARY PSYCHIATRIC SERVICES AS THE DOCTOR DEEMS ADVISABLE.

_____ _____
SIGNATURE **DATE**

I CERTIFY THAT THE FOLLOWING IS TRUE AND CORRECT LIST OF BEHAVIORAL MEDICATIONS THAT I AM CURRENTLY TAKING.

1._____mg_____DIRECTIONS:_____

2._____mg_____DIRECTIONS:_____

3._____mg_____DIRECTIONS:_____

4._____mg_____DIRECTIONS:_____

5._____mg_____DIRECTIONS:_____

6._____mg_____DIRECTIONS:_____
(PLEASE USE THE BACK SHEET FOR ADDITIONAL SPACE IF NEEDED.)

I CERTIFY THAT THE FOLLOWING IS TRUE AND CORRECT LIST OF MEDICATIONS THAT I AM CURRENTLY TAKING FOR MY **GENERAL HEALTH CONDITIONS**.

1._____mg_____DIRECTIONS:_____

2._____mg_____DIRECTIONS:_____

3._____mg_____DIRECTIONS:_____

4._____mg_____DIRECTIONS:_____

5._____mg_____DIRECTIONS:_____

6._____mg_____DIRECTIONS:_____
(PLEASE USE THE BACK SHEET FOR ADDITIONAL SPACE IF NEEDED.)

ALLERGIES:_____

_____ _____
SIGNATURE **DATE**

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OFFICE RULES (Please initial after each statement to acknowledge your understanding)

1. ALL COPAYS MUST BE PAID IN FULL BEFORE SERVICES ARE RENDERED. WE RESERVE THE RIGHT TO NOT TREAT ANY PATIENT WITH AN UNPAID BALANCE. _____ (INITIALS)

2. IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY US BEFORE THE VISIT OF ANY INSURANCE CHANGES OR ANY UPDATES. IF WE RECEIVE AN UNPAID CLAIM BECAUSE A PATIENT FAILED TO NOTIFY US OF AN INSURANCE CHANGE, THEN THE PATIENT WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF THE VISIT. THERE WILL BE A 10% COLLECTION FEE ADDED TO YOUR ACCOUNT IF YOU HAVE NOT PROPERLY NOTIFIED US OF ANY CHANGES IN YOUR INSURANCE COVERAGE AND/OR ANY OF THE ABOVE ACTIONS OCCUR. _____(INITIALS)

3. THE PATIENT WILL HAVE 90DAYS TO PAY DUE BALANCES. AFTER 90 DAYS OF NON PAYMENT THE PATIENTS UNPAID BALANCES WILL BE TURNED OVER TO A COLLECTION AGENCY AFTER 90 DAYS OF REPEATED NON PAYMENT (THE PATIENT WILL HAVE 30 DAYS TO FIND A NEW PROVIDER ONCE THEY HAVE BEEN NOTIFIED THAT THEIR ACCOUNT HAS BEEN TURNED OVER TO COLLECTIONS AND WILL NO LONGER BE A PATIENT). THE DOCTOR WILL SEE THE PATIENT ONE TIME WITHIN THAT 30-DAY TIME FRAME TO REFILL MEDICATIONS TO ALLOW THE PATIENT ADEQUATE TIME TO FIND ANOTHER PROVIDER. NO EXCEPTIONS! _____(INITIALS)

4. PATIENT SHOULD CANCEL THEIR APPOINTMENTS BY THE END OF THE PREVIOUS WORKING DAY OF THEIR APPOINTMENT TIME. 3 NO CALL NO SHOWS WILL LEAD TO PATIENT BEING DISCHARGED. NO EXCEPTIONS! _____(INITIALS)

5. ALL NEW/ESTABLISHED PATIENTS VISITS MUST BE PAID IN CASH OR CREDIT. NO CHECKS! NO EXCEPTIONS! _____(INITIALS)

6. WE WILL NOT TREAT ANYONE BELOW THE AGE OF 5 YEARS, OR ANYONE OVER THE AGE OF 65 YEARS. _____ (INITIALS) NO EXCEPTIONS!

7. MEDICAL RECORDS FROM OTHER PROVIDERS, FOR REVIEW BY DR. KULKARNI, MAY BE SENT TO THE OFFICE ADDRESS AS ABOVE. WE WILL ACCEPT COPY OF RECORDS VIA PHYSICAL MAIL OR IN PERSON, DURING OFFICE HOURS. RECORDS MUST BE RECEIVED BEFORE THE TIME OF APPOINTMENT, TO ALLOW FOR ADEQUATE TIME FOR REVIEW. NO RECORDS WILL BE ACCEPTED BY FAX! COPIES OF RECORDS REQUESTED BY THE PATIENTS FROM OUR OFFICE WILL HAVE A CHARGE AS FOLLOWS: $35-10 PAGES OR LESS AND $50- 10 PAGES OR MORE. _____ (INITIALS) NO EXCEPTIONS!

8. ANY PRESCRIPTIONS, LOST OR STOLEN, EVEN IF PATIENT CAN FURNISH A POLICE REPORT, WILL NO LONGER BE HONORED BY DR. KULKARNI. OUR OFFICE WILL NOT REFILL ANY MEDICATION WITHOUT SEEING THE PATIENT FIRST. NO EXCEPTIONS! _____(INITIALS)

9. ONLY PARENTS AND CHILD/OR INCOMPETENT ADULT WITH APPOINTMENT CAN BE ACCOMPANIED BY A (1) PARENT/GUARDIAN TO VISIT. (NO EXCEPTIONS)! ALSO, NO FOOD OR DRINKS ALLOWED IN THE OFFICE. NO CELL PHONES ALLOWED PAST THE WAITING ROOM. NO EXCEPTIONS! _____(INITIALS)

REMINDER: All copays and deductibles are due at the time of service before actually seeing the doctor. Please notify us immediately of any changes in your insurance before your office visit. Failure to do so could result in you having to pay for your visit in full. Payments of delinquent accounts are also due at the time of service. All delinquent accounts will be turned over to collections at the end of 90 days. I understand that if my account becomes delinquent and such debt is given to a collection agency, I will be responsible for any extra charges incurred including all legal expenses. Cancellation of appointments must be made 24 hours in advance, in writing to psychiatry@drkulkarni.net, to avoid a $25.00 charge for no-shows.

Please sign below acknowledging that you have carefully read, initialed, and fully understood all the above statements.

_____ _____

SIGNATURE **DATE**