CONTACT SHEET

First Name _____ **Mid Initial** _____ **Last Name** _____ **Title** _____

Address _____ **City, Zip** _____

Cell Telephone _____ **Home Telephone** _____

Home Telephone _____

Email _____

I agree to be contacted by **(1) both email & cell phone (SMS/voice),** ☐ **(2) cell phone only,** ☐ **(3) e_mail only:** ☐

I agree to receive reminders by **(1) both email & cell phone (SMS/voice),** ☐ **(2) cell phone only,** ☐ **(3) e_mail only:** ☐

Attention: You will be receiving an invitation to the Patient Portal. Please activate it. It will help us to stay in contact using a secure platform. Thank you for helping us to maintain the privacy of our communication.

DOB _____ **Social Security Number** _____

Sex _____ **Marital Status** _____

Referring Physician/PCP _____

Preferred pharmacy _____

Employer _____

Employer Address _____

Emergency Contact Name _____

Emergency Contact Telephone _____

Alternative phone number _____

Alternative Email _____

Insurance Information for Informational Purpose Only:

Insurance _____ **Telephone** _____

Insurance ID _____ **Group** _____

Insurance email: _____

*I understand and agree that I will pay for all services incurred at the time of such services unless other arrangements are made. I understand that I may submit proof to my insurance directly for reimbursement. I understand that my health care insurance carrier or payer for my health insurance benefits may pay less than the actual bill for service. I understand that I am financially responsible for payment in full of all accounts except for Worker's Compensation injuries, Medical Assistance, Medicare, or other fully sponsored government accounts. By signing this statement, I revoke all previous agreement, and I assign **Zahida S. Tayyib, M.D.** any hospital, medical-surgical, and mental health benefits that I am entitled to under the terms of my health care coverage and agree to be responsible for service not paid, in whole or in part by my health care payer.*

x Signature_____ Date_____

Supporting Information

This page provides us with the information requested by the Insurers. Please fill the content before the visit.

Previous Health Providers (Psychiatrists, Psychologists, Therapists)

ID	Name of the Provider (phone, web address)	Start Date	End Date

Medications History

ID	Name of the medication and dosage	Start Date	End Date	Side Effects

Please request or print an additional copy of this page if more space is needed

CONSENT FOR TREATMENT

I, _____ hereby give my consent for any diagnostic or therapeutic services Zahida Tayyib, M.D., including diagnostic evaluation, examination, consulting, psychotherapy and other therapies as appropriate.

I understand that communication between my mental health professional and me is confidential and privileged to the full extent of the applicable laws. Under these laws, the mental health professional may disclose information about me to the staff of Zahida Tayyib, M.D., in the provision of therapy or appropriate referrals, and not otherwise without my written permission.

I further understand that certain circumstances are expectations of the laws of confidentiality, under which a mental health professional is legally required to report.
These include:

1. Intent to harm myself (suicide)
2. Intent to harm another person
3. Child abuse, physical and /or sexual
4. Domestic violence

If a mental health professional reasonably believes that one of the exceptions applies, he or she will make every effort to resolve the issue by discussing it with me before reporting to the appropriate agency.
I understand that in group therapy, there is a risk of disclosure of my confidential information by other group members, and I will not hold the mental health professional liable for any breach of confidentiality by other group members.

I have read and agree to abide by the above policies.

_____ Signature

_____ Date

CONSENT FOR RELEASE OF PATIENT RECORDS

I, _____ hereby authorize Dr. Zahida Tayyib to disclose records obtained in the course of my diagnosis and treatment for: _____.

☐ Complete Record ☐ Email Communications

☐ Oral Communications ☐ Other

☐ Records of care, limited to dates **From:**_____ **To:**_____

To (*name and address of the organization to which disclosure is made*) _____

_____

_____

This release is reciprocal, meaning that the provider or facility listed above may release medical information in written, oral, and/or email form to Zahida Tayyib, MD.

_____ _____

Date *Patient, Parent or Legal Guardian Signature*

CONSENT FOR TREATMENT WITH MEDICATION

I, _____, a patient of Dr. Zahida Tayyib. Who informed me that she recommends that I receive the medication below for the treatment of my condition:

_____ Neuroleptic
_____ Antidepressant
_____ Antianxiety
_____ Lithium
_____ Other

Dr. Tayyib has informed me of the nature of the treatment and has also explained to me the risks, benefits, and possible side effects. I understand that there may be other side effects, and I agree to promptly inform the physician and another member of the staff if there are any unexpected changes in my condition.
I am aware that abruptly stopping any medication may cause serious problems, and that any changes in medication should be discussed first with my physician.

_____ _____
Date *Patient, Parent or Legal Guardian Signature*

I have explained the side effects from the use of _____ medication to _____, the patient. I believe that this patient is able to make an informed and voluntary decision about the use, or continued use, of _____ medications.

_____ _____
Date *Zahida Tayyib, MD*

Comments _____

Notice of Policies and Practices to Protect the Privacy of Your Health Information (HIPAA Notice)

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

Under the Health Insurance Portability and Accountability Act ("HIPAA"), a federal law, I am required to maintain the privacy of your protected health information and provide you with notice of my legal duties and privacy practices concerning such protected health information.

How I May Use or Disclose Your Health Information

I may use or disclose your protected health information for treatment, payment, and health care operations purposes with your authorization. To help clarify these terms, here are some definitions:

- *Protected Health Information (PHI)* refers to information in your health record that could identify you.
- *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care.
- *Payment* is when I obtain reimbursement for your health care.
- *Health Care Operations* are activities that relate to the performance and operation of my practice.
- *Use* applies only to my activities, such as applying, utilizing, examining, and analyzing information that identifies you.
- *Disclosure* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
- *Authorization* is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

The following categories describe different ways that I may use and disclose PHI. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of these categories.

Uses and Disclosures Requiring Authorization

For treatment. I may use or disclose your PHI to provide, coordinate, or manage health care and treatment. For example, I may consult with another health care provider, such as your family physician, your neurologist, your psychologist, or another psychiatrist. With your written authorization, I may also disclose information about you to other people who may be involved in your care, such as family members.

For payment. I may need to disclose PHI about you to determine eligibility or coverage, or so that treatment and services you receive from me may be billed, and payment may be collected from you, an insurance company, or a third party. For example, I may need to disclose information about the services you receive from me so your health plan will pay me or reimburse you for the services. Your health plan provider may be told about a treatment you will receive to determine whether your plan will cover the treatment. Again, I will obtain written authorization to disclose this information.

Business Associates. I contract with service providers – called business associates – to perform various functions on my behalf. For example, I may contract with a service provider to perform the administrative functions necessary to submit your medical claims. To perform these functions or provide the services, business associates will receive, create, maintain, use, or disclose PHI, but only after I and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your information.

For health care operations. I may use and disclose PHI about you for office operations. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. These uses and disclosures are necessary to run my office and make sure that all patients receive quality care.

Appointment reminders. I may use and disclose medical information to contact you as a reminder that you have an appointment with me. For example, a message may be left on your answering machine. You have the right to be contacted by another method if you prefer. However, you must inform me in writing about your preference, and I must agree to that request. If I agree to your request, I am bound to abide by it.

Additional Disclosures Without Authorization

I may use or disclose information related to your care without your consent or authorization in the following circumstances:

Serious Threat to Health or Safety. I may disclose your confidential information to protect you or others from a serious threat of harm by you. I may communicate relevant information concerning this to the potential victim, appropriate family members, or law enforcement or other appropriate authorities.

Child Abuse. If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or another person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to Santa Clara County Child Protective Services or an appropriate law enforcement agency.

Adult and Domestic Abuse. If I know, or have reasonable cause to suspect, that a vulnerable adult (dependent or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to Santa Clara County Adult Protective Services or an appropriate law enforcement agency.

Health Oversight. The California Board of Psychology has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.

Judicial or Administrative Proceedings. If you are involved in a court proceeding, and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Other uses and disclosures of PHI not covered by this notice or applicable laws will be made only with your written permission. If you provide me permission to use or disclose medical information about you, you may revoke this permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that you may not revoke an authorization to the extent that I have relied on that authorization; or if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Your Rights Related to HIPAA and Protected Health Information (PHI)

As my patient, you have the following rights regarding PHI that is maintained about you.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of PHI about you. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing. In your request, you must tell me 1) what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that I see you. Upon your written and approved request, messages for you can be left by another method). To request confidential communications, you must make your request in writing. I will not ask you the reason for your request. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to inspect and copy. You have the right to inspect and copy PHI that may be used to make decisions about your care as long as this information is maintained in the record. To inspect and copy information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, I may charge a fee for the cost of copying, mailing, or other supplies associated with your request. I may deny your request to inspect and copy in certain limited circumstances.

Right to Amend. You have the right to request an amendment of your PHI for as long as this information is maintained in the record. On your request, I will discuss with you the details information of the amendment process.

Right to an Accounting. You generally have the right to receive an accounting of disclosures of your PHI for which you have neither provided consent nor authorization. On your request, I will discuss with you the details of the accounting process.

Right to a paper copy of this notice. You have a right to a paper copy of this notice.

My Responsibilities Related to HIPAA and Psychological Records

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices concerning PHI. I reserve the right to change the privacy policies and practices described in this notice as required by changes in state and federal law regarding PHI. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with the changes either by giving you the revisions in person or by mail.

I, _____, have received a copy of these Policies and Practices to Protect the Privacy of Your Health Information.

X Signature_____ Date_____

AUTHORIZATION FOR

RELEASE CONFIDENTIAL PATIENT INFORMATION AND FINANCIAL UNDERTAKING

Patient Name:_____

I hereby authorize Dr. Zahida S. Tayyib to release any medical information in my file to my insurance companies to process insurance claims.

I understand that arrival delays or late cancellations may prevent other patients from getting treatment. I understand that **I will be charged $75.00 for appointment cancellation made within 24 hours before scheduled time.** I also understand that timely arrival is critical, and if I am late by 15 minutes from the scheduled time, I may need to wait for the next available opening.

Date *Patient, Parent or Legal Guardian Signature*

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Date *Patient, Parent or Legal Guardian Signature*