RAJU INDUKURI, M.D

New Patient Demographic Information

Date:_____ Provider: **Dr. Raju V.Indukuri, M.D , Psychiatrist**

Name:_____(Nick Name):_____

Address:_____ City:_____ State:___ Zip:_____

Phone#:_____ Alt Phone#:_____DOB:_____

E-Mail address:_____ Gender (Male)_____(Female)_____ Age_____

For patients under the age of 18, please fill out the section below.

Mother/Legal Guardian:_____ DOB:_____SSN#:_____

Relationship to the minor:_____

Employer:_____ Work Phone #:_____

Father/Legal Guardian: :_____ DOB:_____SSN#:_____

Relationship to the minor:_____

Employer:_____ Work Phone #:_____

INSURANCE INFORMATION (used only for the purpose of medication prior approvals)

Insurance Company/HMO:_____ Phone #:_____

Member ID #:_____ Primary Insured Name:_____

Primary Date of Birth:_____ Primary SSN #:_____ Employer:_____

Relationship to Patient:_____

Primary Care Physician:_____ Phone #:_____

*******NOTIFY IN CASE OF EMERGENCY*******

Name:_____ Relationship To Patient:_____

Phone #:_____ Alternate #: _____

Current Psychiatrist/Physician Name:_____ Office Phone#:_____
Current Psychiatric Medications: _____
_____
Past Psychiatric Medications: _____

Past Psychiatric Treatment- (Mental Health, Chemical Dependency or Hospitalization)
_____
_____

Current Primary Care/Physician Name:_____ Office Phone #: _____
Current Medications:_____
_____

Other Medical conditions (diabetes, hypertension, head traumas, cardiac problems, cancer, asthma or other breathing problems, etc.)
_____
_____

Hospitalizations/Surgeries-(Include dates, complications, adverse reactions to anesthesia and outcomes)
_____
_____

Results of recent lab tests and consultation reports:_____
_____

Family Mental Health or Chemical Dependency History:_____
_____
_____

Previous Medical History: (Allergies, adverse reactions to medications, food and etc.)_____
_____

Military/Legal/Marital History:
_____
_____

Substance Abuse History

Substance	Amount	Frequency	Duration	First Use	Last Use
Alcohol					
Tobacco					
Hallucinoges					
Marijuana					
Opioids/Narcotics					
Cocaine					
Others					

PAYING FOR APPOINTMENTS

NEW PATIENTS: ONCE YOU ARE GIVEN AN APPOINTMENT, YOU WILL BE PROVIDED AN ACCOUNT NUMBER. YOU CAN PAY ON OUR WEBSITE **DRINDUKURI.COM.**

Please use the green payment button 

and fill out the information including your valid email address and account number. If you do not know or remember your account number, please contact our office.

Medication Authorizations:
There will be an additional charge for prior authorizations.

Other Fees:
There will be a charge for additional high complexity administrative tasks for medical and non-medical paperwork involving written documents such as forms, records, or letters.

Late Charges / No Show Charges :
I understand that canceling an appointment without giving 24 hours' notice may result with a cancelation fee. I the guarantor, patient or financial responsible party understand that if the patient fails to show for an appointment that a missed appointment charge will be placed on the account.
You receive a "Late Cancellation" or "No Show" charge on the patient's statement and want the charge removed, send the statement back to the office with an explanation as to why the appointment was missed so it can be presented to the physician so that he can make a determination as to approve or disapprove.

Patient Name:_____

X_____ _____

Guarantor/Patient/Financial Responsible Party's Signature *Date*

INFORMED CONSENT FOR TREATMENT

I, _____ consent to participate in behavioral care services offered and provided by the physician, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the provider is qualified to provide within: (1) the scope of the provider's license, certification and training; (2) the scope of the license, certification and training of behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____

Patient/Responsible Party's Signature Date

CONSENT FOR MEDICATION

Dr Indukuiri,M.D has educated me regarding the medication that has been prescribed to _☐_me, _☐_my child, or _☐_ a person for whom I am the legal guardian and I consent to the administration of this medication. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication and the possible effects of this medication if the person taking it becomes pregnant. I have also been informed of the reason or purpose for which this medication was prescribed. Dr.Indukuri has given me/my child opportunity to ask questions about the medications. I fully understood the information provided for the treatment. I am in agreement with possible current and future side effects from the medications.

_____

Patients Name

_____ _____

Patient/Responsible Party's Signature Date

_____

Provider's Signature

- It is recommended that women who are or may become pregnant, or are breast-feeding discuss this with their doctor **before taking any medication.**
- It is recommended that patients be educated on reporting all side effects they experience, including, but not limited to, which side effects to report **immediately** to a health care provider.
- It is recommended that any provider prescribing medications obtain a thorough patient history that should include (but may not be limited to):
    1. What medications, including prescribed and over-the-counter medications the patient is or has been taking.
    2. What food and drug allergies the patient has.
    3. What medical conditions the patient has.

PATIENTS RIGHTS AND RESPONSIBILITIES

Patient's Name:_____

Our practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine the bill.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g., allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone number and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medications(s), alternative, i.e., herbal or other, therapies, or over-the-counter medications you take.
- Telling your clinician about any changes in your condition, or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the office at least 24 hours in advance. There is a $60 charge for missed appointments and appointments cancelled without 24 hours' notice.
- Paying co-payments at the time of the visit or other bills upon receipt. You will be asked to reschedule your appointment if you cannot pay you co-pay at the time of service.
- Following the office's rules about patient conduct: for example, there is no smoking, eating, or drinking in the office.
- Respecting the rights and property of our staff and other persons in the office

By signing below you acknowledge you have read, understand and agree in these rights and responsibilities.

_____ _____

Signature of Patient/Guardian *Date*

PATIENT CONSENT TO TREATMENT AND MEDICATION MANAGEMENT

Patient Name:_____

I do herby authorize Dr. Raju Indukuri, M.D. to provide necessary treatment.
Dr. Indukuri has provided me with a general explanation of the nature of the treatment and the reasons for its indication of my particular emotional conditions. Dr.Indukuri has also discussed with me the risks and benefits of the treatment that includes therapy and medication management including all other alternatives

Medications that I am giving consent for:

_____

_____

Dr. Indukuri has provided all available alternative treatments, the common side effects, and the benefits of the above medications. I agree to comply with medications prescribed and take a drug screen whenever given for compliance.

After discussing all of the above, Dr. Indukuri gave me an opportunity to ask questions and seek further information regarding the above medications and therapy. I believe that I do not require further information at this time and I am prepared to proceed with the recommended treatment. I believe that my physician has honored my right to make my own informed health care decision. I give my consent voluntarily and freely, and certify that I can give valid consent (that is, I am not a minor or incompetent to make my own health care decisions). I understand that I can revoke this consent at any time up until the time that the treatment or procedure is started.

_____ _____
Signature of Patient Witness

_____ _____
Date Time

If patient is unable to sign or is a minor complete the following:

Patient is a minor ☐

Patient is unable to sign ☐

_____ _____
Signature of Parent or Legally Authorized Representative Relationship to Patient

Consent for Release of Confidential Information to Primary Care Physician

Primary Care Physician Name:_____

Patient Name:_____ SSN #:_____

By initialing all information items I approve, I authorize release of the following medical information to the Health Care Practitioner named above. **Check and initial ALL that apply:**

☐ Mental Health Diagnosis_____

☐ Medication Management Information_____

☐ Other Mental Health Treatment Information_____

☐ Other Information Specified Here_____

☐ Substance Abuse (SA) Information_____

For SA Information, this authorization is:

☐ Limited to the Following Treatment_____

☐ Limited to the Following Time Period_____

OR

☐ I do **NOT** wish to have information shared with my PCP/ Medical Practitioner

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibits anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

_____ _____

Signature of Patient/Legal Guardian *Date*

_____ _____

Signature of Witness *Date*

RAJU INDUKURI, M.D.
2900 FELICIA ST. STE 103, NASHVILLE TN, 37209
PH:615-649-O676 FAX:615-649-0671

HIPPAA

I have read and will be given a copy, by request, of The Notice of Private Practices for the Nashville Therapy Center and I acknowledge receipt of these documents.

I am a patient of Dr. Raju Indukuri and I understand I may review the Policies and Procedures Manuel for HIPPA Compliance, to protect my confidential medical information and all processing necessary for my care at any time.

_____ _____

PATIENT/ PARENT/ GUARDIAN SIGNATURE *DATE*

RAJU INDUKURI, M.D.
2900 FELICIA ST. STE 103, NASHVILLE TN, 37209
PH:615-649-O676 FAX:615-649-0671

GUIDELINES AND POLICY FOR SCHEDULE 2 and SCHEDULE 3 DRUG TESTING

1. Every new patient will be given an oral drug test to establish a baseline for the patient's profile.
2. Every patient who loses his or her pills and/or prescriptions will be asked to take an oral drug test.
3. Every patient who has a change in his or her medication will be given an oral drug test to establish a new baseline.
4. Patients who do not take an oral drug test or fail an oral drug test will not get a new prescription until a clean oral drug test is obtained.
5. Should an illegal drug appear in the final report from the laboratory, it will be the decision of the physician as to continue treatment of the patient with the prescribing of Schedule II and Schedule III drugs.
6. All patients who are prescribed Schedule II and Schedule III drugs will be subjected to this policy and by establishing patient baselines with a Schedule II or Schedule III drug we will be offering our patient a more complete diagnosis and also we will be meeting or exceeding DEA guidelines.

This will be our established policy with no exceptions as of the date below.

_____ _____

PATIENT/ PARENT/ GUARDIAN SIGNATURE *DATE*

END OF FORM