Taral Sharma, M.D., P. C.
(D.B.A.: Carolina Psychiatry)
Phone: (864) 844-9432
Fax: (864) 844-9430
www.carolinapsychiatry.com

"EXCEPTIONAL EVIDENCE BASED PATIENT CARE"

Your Information:

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ DOB: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____

Zip Code: _____

Marital Status: (Please check one)

⬭ Married ⬭ Single ⬭ Divorced ⬭ Legally Separated

⬭ Widowed ⬭ Partnered ⬭ Other

Contact Information:

Main Phone: _____ (circle one) Cell Home Work

Secondary Phone: _____ (circle one) Cell Home Work

E-mail: _____

Would you like to receive appointment reminders?

Yes No

If you circled yes, how would you prefer to receive these appointment reminders?

Call Text E-mail

Do you give us permission to leave voicemails?

Yes No

Patient Signature: _____ Date: _____

Emergency Contact Information:

Name:_____ Phone: _____

Relationship to you: _____

Additional Information:

Who is your Primary Care Doctor? _____

Phone: _____ Fax: _____

Address: _____

Preferred Pharmacy: _____ Phone: _____

Address: _____

Medication Information:

Please list all current medications

Medication Name	Dosage	Frequency	Prescriber

Do you have any allergies? (Please list all allergies including drug allergies)

_____

_____

Please briefly describe the problems for which you are seeking help at this time.

_____

_____

_____

When did the problem(s) begin? _____

_____

Taral Sharma M.D., P.C.

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Fax: 864-844-9430

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____

I authorize Taral Sharma M.D., P.C. to release and request my medical records from the following recipients:

(Please list any health care provider or family member that you allow to have access to your medical records).

1. Name: _____ Facility: _____

   Address: _____ City: _____ State: _____ Zip Code: _____

   Phone: _____ Fax: _____

2. Name: _____ Facility: _____

   Address: _____ City: _____ State: _____ Zip Code: _____

   Phone: _____ Fax: _____

Please see the following list of information that could potentially be discussed with the above listed person(s):

Psychiatric Evaluation, Psychological Testing Reports, Social History, History and Physical Examination, Consultations, Laboratory Reports, Progress Notes, Discharge Summary, Aftercare Plan/ Recommendations, Continued Treatment, Review and discuss care plans to coordinate treatment between providers.

I further agree to indemnify and hold harmless the party releasing the records from any liability that may arise from the release of the information herein requested.

If, on the judgment of the party releasing the records, disclosure of the privileged/confidential information will be harmful to the patient, release of such information may be withheld in accordance with specific State and Federal regulations. Records released may contain alcohol and drug treatment

information, AIDS/HIV, psychiatric/psychological/other mental health privileged or confidential information. Certain communications are privileged and not subject to release without your consent under State and/or Federal law.

After giving due consideration to the above statement, I authorize the party specified above to furnish information, including electronic, photostatic or faxed copies of my medical record, including matters privileged under the laws of the State of Georgia, and applicable Federal laws and regulations, to the above organization/individual, or its agents.

I understand that this Authorization is subject to revocation, in writing at any time except to the extent that action has been taken in reliance thereof, and is valid indefinitely from the date of my signature, unless I specify another date or event here:

Patient Signature: _____ Date: _____

Witness Signature: _____

Legal Gaurdian Signature: _____

Taral Sharma M.D., P.C.

No Show Missed Appointment Office Policy &

Patient Provider Relationship Agreement

When our office schedules your appointment, we are setting aside a dedicated time slot just for you. We ask that if you reschedule your appointment, that you please let us know 24 hours in advance.

If you no call no show your appointment you will be charged $100 no show fee. Your insurance will not be responsible for paying this fee.

If you are more than ten minutes late for your appointment, we will need to reschedule your appointment. We reserve these time slots specifically for you. If you are late, your appointment time runs over into the next patient's appointment time causing scheduling conflicts and less time for other patients to be seen.

If you no call no show three times, this will result in loss of future appointment privileges.

Patient Signature: _____ Date: _____

Patient Provider Relationship Agreement

Your relationship with your doctor is at your discretion. You have the right to seek mental health treatment from any provider with whom you feel comfortable. If you have concerns about the quality of services provided, concerns with staff, building, or billing, please let your provider know. Awareness of these issues will strengthen our working relationship and in no way effect the quality of care you receive at our clinic.

We reserve the right to terminate services provided by our office if anyone behaves inappropriately towards a provider or office staff, if there is non-compliance with attending appointments, providing payment for services, or if either patient/parent does not consent for services for a child. Your signature below indicates that you have read the above information and agree to abide by these terms during our professional relationship.

Print Name: _____

Patient Signature: _____ Date: _____

Taral Sharma M.D., P.C. Informed Consent to Treatment Form

At my own discretion I am requesting treatment at Taral Sharma M.D., P.C. I know that my treatment may consist of pharmacotherapy and/or psychotherapy. I will be educated on the benefits and potential side effects or reactions that may result from any prescribed medication. I am aware that I have the right to request a copy of the Physician Desk Reference for my use. I have the right to ask questions regarding my treatment and expect that my questions will be answered to my full satisfaction. If I do withdraw from treatment, I have the right to have a referral sent to another practitioner for alternative treatment.

I allow Taral Sharma M.D., P.C. to make this document a permanent part of my patient record.

I understand and will expect that all papers and documents concerning my treatment at Taral Sharma M.D., P.C. will be kept confidential. My treatment information cannot be released with out my written consent unless required by law or in a situation that is potentially life-threatening. According to Federal Regulations, licensed providers are mandated to report information that professional judgement would determine constitutes threat or serious harm to self or others, or indicates child or elder abuse or neglect. You have my consent, without reservation, to release any such information about me without further written approval.

Patient Name printed: _____

Patient/Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Taral Sharm M.D., P.C.

Telepsychiatry Patient Consent Form

In order to receive telepsychiatry services from Taral Sharma M.D., P.C., you must be a South Carolina State resident.

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

The potential benefits of telepsychiatry include, but are not limited to:

- A telepsychiatry session will not be exactly the same, and may not be as complete as a face-to-face service.
- There could be some technical problems (video quality, internet connection) tha may affect the telespsychiatry session and affect the decision-making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide or arrange for emergency care that you may require.
- A lack of access to all the information that might be available in a face to face visit, but not in a telepsychiatry session, may result in errors in judgment.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Taral Sharma M.D., P.C. utilizes software that meets the recommended standards to protect the privacy and security of the telepsychiatry sessions. However, the service cannot guarantee total protection against hacking or tapping into the telepsychiatry session by outsiders. This risk is small, but it does exist.

Alternatives to the use of telepsychiatry:

- Traditional face-to-face sessions.

I understand that I have the following rights with respect to telepsychiatry:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telepsychiatry interaction to researchers or other entities shall not occur without my written consent.

3. I understand that there are risks and consequences from telepsychiatry, including, but not limited to, the possibility, despite reasonable efforts on the part of m psychiatrist/therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

   In addition, I understand that telepsychiatry based services and care may not be as complete as face-to-face services. I also understand that if my psychiatrist/therapist believes I would be better served by another form of psychiatric services (e.g. face-to-face services) I will be referred to a psychiatrist/therapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry, and that despite my efforts and the efforts of my psychiatrist/therapist, my condition may not improve, and in some cases may even get worse.

4. I understand that I may benefit from telepsychiatry, but that results cannot be guaranteed or assured.
5. I understand that I have a right to access my medical information and copies of medical records in accordance with South Carolina Law.

   Patient's Responsibilities

   I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.

   I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before our session begins.

   I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I must be a resident of the State of South Carolina to be eligible for telepsychiatry services from Taral Sharma M.D., P.C.

   I understand that my psychiatrist/therapist determines whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.

   I understand that if the telepsychiatry session does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow-up face-to-face visit, or a second telepsychiatry visit.

I can change my mind and stop using telepsychiatry at any time, including in the middle of a video visit. This will not make any difference to my right to ask for and receive health care.

Patient Consent to The Use of Telepsychiatry:

I hereby consent to engaging in telepsychiatry with Taral Sharma M.D., P.C. as part of my psychiatric evaluation and treatment. I understand that "telepsychiatry" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read and understand the information provided above regarding telepsychiatry.

Patient Name Printed: _____

Patient Signature/Legal Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

Taral Sharma M.D., P.C. Non-covered services agreement:

Introduction:

Like many new procedures, it will be difficult or impossible to get reimbursement for Esketamine administration codes. Insurance reimbursement for our more traditional services will be similar for Taral Sharma M.D., P.C. as for other providers you may have used. In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled, however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). We will provide you with a copy of any report we submit if you request it. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above unless prohibited by contract.

Agreement:

I, _____ being a patient of Taral Sharma, M.D., P.C.do hereby acknowledge that it has been explained to me the following services are not or may not be covered by the benefits available to me under the terms of my health plan or insurance policy:

- CPT Codes (90791-90792) – Psychiatric diagnostic evaluation

- CPT Codes (90833-90837) – Psychotherapy

- CPT Codes (99212-99215) – Regular outpatient visit

- CPT Codes (99415,99416) – Prolonged clinical staff service

- CPT Codes (90867, 90868, 90869) – Transcranial Magnetic Stimulation (TMS)

- CPT Codes (99358, 99359) – Prolonged evaluation

- CPT Codes (G2082, G2083)

- Any other CPT Code Procedures

I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and supplies. Some services may be determined to be not medically necessary, investigational, or not eligible because they are newer treatment modalities, maintenance, prevention, or wellness care in nature.

I acknowledge that I have been told in advance of treatment, what portion of my care is considered not covered by my health plan or insurance policy, and I agree to make financial arrangement with my practitioner to pay for these services.

Patient Signature: _____

Patient's Printed Name: _____

Dated: _____

Acknowledgement:

I understand that Taral Sharma M.D., P.C. will file my insurance and that all monies for services rendered are due on the day of service.

I acknowledge that Taral Sharma M.D., P.C. provided me with the option to obtain a written copy of Notice of Privacy Practices.

I also acknowledge that I have been offered the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature: _____ Date: _____