Freehold Child Diagnostic Center, Inc.

SAJJAD A. ZAIDI, M.D. & ASSOCIATES

Diplomate: American Board of Psychiatry & Neurology
In the Specialty of Psychiatry & Medical Subspecialty of Child & Adolescent Psychiatry
Diplomate: American Board of Addiction Medicine

Patient Information

Patient Name: _____

Mailing Address: _____

City/Town: _____ State: _____ Zip: _____

Date of Birth: _____ Marital Status: _____ Sex: _____ Age: _____

PRIMARY Telephone #: _____
*This is the number that we be called for confirmation calls, any lab/medical reports, etc. Messages will be left at this number unless specified otherwise _____

PRIMARY Email: _____
*This is the email that will receive confirmation emails, receipts, etc.

Referred By: _____

Parent/ Guardian Information if patient is under 18 years old

Last Name: _____ First Name: _____

Email Address: _____Birthdate: _____

Marital Status: _____Sex: _____ Telephone: _____

Work Phone: _____ Cell Phone: _____

I hereby consent for the above named patient to be treated by the staff of Freehold Child Diagnostic Center, Inc. I understand that I am financially responsible for all charges. All payments MUST be made in full at the time of session. If appointments for ANY reason are not paid for, refills will not be provided until the balance is paid. If there is an outstanding balance on your account, your upcoming appointment will be cancelled. There is a $35.00 return check fee. We do not accept insurance; all sessions are to be paid in full by check, cash, Visa or MasterCard at the time of your session.

**** All appointments must be cancelled 24 hours before your scheduled appointment time; otherwise you will be charged the full session fee. No exceptions. Appointments can be cancelled via email to Zaidimd501@aol.com or by calling 732-761-1900 and leaving a message as both methods will record the time of the cancellation ****

Signature of Parent or Patient if 18+: _____

Printed Name of person signing: _____ Date: _____

Freehold Child Diagnostic Center, Inc.

Office Policies

Compliance with appointments is mandatory if you are on medications; you must schedule your appointments for when the provider is requesting to follow up with you. Every patient is different and every medication prescribed is different. If you have a 90-day prescription plan, you MUST be seen before the 90 days expires to receive an additional 90-day refill. If you cannot make it in, monthly refills will be given until you can come for a follow up appointment. If more than 90 days has passed without a scheduled appointment, we will only provide a partial refill until you can come in for an appointment. If you fail to make an appointment, a termination of care letter will be sent due to noncompliance and no further refills will be given. This is not only office policy, but the strict guidelines that providers have to follow when prescribing medications, especially controlled substances. Controlled prescriptions that can be called in will not be sent to mail away or given in three-month increments. Controlled prescriptions are NOT auto renewed; therefore you must request them either by email or by leaving a message on our machine and we can either mail it to you or you can choose to pick it up. We recommend you request them a week in advance to ensure you receive them in a timely manner and do not run out. The Freehold office is typically open for pickups Monday-Thursday 10-4, Neptune office hours vary so please call prior to coming. *Please keep in mind the office can be closed for holidays etc. so please request your refill timely. If you are seen for an after hours appointment with a prescriber, your medications will be sent to your pharmacy the following business day.

Any of the FCDC staff can request a urine sample at any time. If you cannot produce a urine sample at the time of session you are welcome to wait, or you MUST return to our office within 48 hours to give us the sample. If the sample is not given within 48 hours, regardless of reasoning, your medications (if any) will be tapered down and discontinued appropriately or we have the right to terminate care completely for noncompliance of treatment planning.

If you fail to show for your appointment or you cancel without 24 hours notice, you will be charged for your session in full; your fee will not be reduced if you opt to do a phone consult. Phone consults are only for emergency situations only and regardless of the reasoning, two phone consultations CANNOT be done back to back. No show fees will be payable by you and cannot be processed through your insurance company. We will very often place a courtesy call/email reminder to remind you of your appointment, however it is just a courtesy and this should not be solely relied upon for you to remember your scheduled appointment date and time. You are responsible for remembering all appointments that you schedule. Should you not be seen in over a years time, you will be required to schedule a new Psychiatric Evaluation.

This office often uses email as a primary mode of communication to provide the fastest form of communication to meet our patient's needs. We will transmit clinical information as well as appointment, payment, and medication information, etc. If you provide an email address, you are giving permission to communicate this information electronically. Patients are welcome to email questions, concerns or paperwork, however if this gets excessive or the provider feels at any time an appointment or phone consultation is needed, this will be relayed to you by the office staff.

Minors of divorced parents that present for an appointment must have consent of both custodial parents to be treated. We assume that by you scheduling an appointment, both parents are in agreement with the treatment. It is solely parental responsibility to make sure they have the legal right to make medical decisions regarding their child and our services. If necessary, the custody agreement should be provided automatically from the parent to the office.

I have read and agree to all of the above statements:

Signature of Parent or Patient if 18+: _____

Printed Name of person signing: _____Date: _____

Patient name if different from person signing_____

Freehold Child Diagnostic Center, Inc.

Office Policies Regarding Medication

Please <u>initial</u> below next to the following statements:

_____ I agree to follow the dosing schedule prescribed to me by my prescriber.

_____ I agree to never share my medications with others, nor will I sell or exchange my medications for any reason.

_____ I agree to always keep my medications safeguarded and within my control.

_____ It is my responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three business days so please be courteous and do not wait to call. Medication refills will be given during regular business hours, Monday-Friday from 10:00am-4:00pm. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out. You may email or call and press "2" for medication refills. No controlled prescriptions will be refilled on Saturday, Sunday or Holidays.

_____ Please note that if you need refills for your medications, we ask that you contact FCDC directly via email/voicemail so that we can escribe to your pharmacy. FCDC does not receive requests from pharmacies via our electronic health records (which is how most large chains communicate their refill requests).

_____ If you are prescribed MEDICINAL MARIJUANA, please contact the office prior to going to the dispensary to make sure your prescription was sent and ready for pick-up.

_____ Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. Prior authorization will be attended to as quickly as possible. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication.

_____ It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every three months, no exceptions. A two month follow up appointment is needed for Medicinal Marijuana and Suboxone.

_____ I agree that if I receive narcotic or controlled medication prescriptions from FCDC, I am not allowed to receive the same type of medications from another physician without express consent or consultation with your prescriber.

_____ If a minor's parents are divorced, it is the attending parent's responsibility to notify parent of medication that has been prescribed. If a parent cannot be in attendance for the evaluation, they should be available by phone to avoid conflict regarding recommendations or medical decisions made by your prescriber.

_____ I understand there will be no early refills of any narcotic or controlled medications prescriptions.

_____ New symptoms or events require an appointment. Your prescriber will not diagnose or treat over the phone/ email.

_____ I understand that not disclosing medications that I take which have addictive potential is a serious breach of the physician-patient relationship. I pledge that I will not seek prescriptions from other providers for these types of medications without the prior knowledge and agreement from your prescriber. I understand that violation of this pledge may result in termination of care.

Printed Name of person signing: _____ Date: _____

Patient name if different from person signing: _____

Freehold Child Diagnostic Center, Inc.

Office Fees

We do not accept insurances and we are considered out of network. Payment is due in full at the time of service, no exceptions. We take Visa, MasterCard, Check or Cash. You will receive a receipt to submit to your insurance company should you have out of network benefits and may be able to be reimbursed. IT is your sole responsibility to know your insurance benefits. The cost of appointments are as follows:

Psychiatrists		Nurse Practitioners	
****up to 15 minutes	$125	****up to 15 minutes	$80
up to 30 minutes	$200	up to 30 minutes	$165
up to 45 minutes	$275	up to 45 minutes	$215
up to 60 minutes	$425	up to 60 minutes	$315

****Only available to longstanding patients whose provider APPROVED up to 15-minute sessions.

Psychiatric Evaluations	$500	Psychiatric Evaluations	$400
Phone Consults (15 min.)	$80	Phone Consults (15 min.)	$80

Therapy	Initial Intake	$190	* Prices are subject change
	Up to 60 minutes	$180	* $35 return check fee
	Up to 45 minutes	$150	* Special request = additional $50
	Group Therapy	price varies	* Other services = price varies

Please note, we always strive to have requests completed as fast as possible, but please keep these time frames in mind when making a request.

Letter or Form. A fee needs to be paid when requesting a letter or form and once paid, it can take up to 14 days for it to be completed.

Medical Records. A fee needs to be paid when requesting medical records based on the amount of records that are requested and once paid, it can take up to 30 days.

I understand the above price list:

Signature of Parent or Patient if 18+: _____

Printed Name of person signing: _____ **Date:** _____

Patient name if different from person signing: _____

Freehold Child Diagnostic Center, Inc.

Consent Disclosure

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below. Description of the specific information *to be discussed* (check all that apply):

_____ Appointment Information _____ Psychiatric Evaluation _____ Medical Labs

_____ Medication Information _____ Alcohol or Drug Information (including urine screenings).

Other (specify) _____

_____

Information to be given to the following parties:

Name/Facility _____

Relationship: _____

Phone/Fax: _____

Email: _____

Name/Facility _____

Relationship: _____

Phone/Fax: _____

Email: _____

I understand that:

I may revoke this authorization in writing by contacting the office.

This authorization is giving Freehold Child Diagnostic Center, Inc. the right to discuss my medical information with the one or more people listed above.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

_____

Patient Name **Date of Birth**

_____

Patient 18+/Parent/Legal Guardian **Date**

MINORS between the ages of 14-18: By federal regulations in pregnancy and drug use or HIV/AIDS related material, separate consent made in writing is needed.

Freehold Child Diagnostic Center, Inc.

Patient Intake Form 1/3

Patient Name: _____ DOB: _____ Age: _____

Person completing form (parent/guardian/self): _____

Sex: O Male O Female O Prefer not to disclose _____

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

Current Symptoms Checklist: (check for any symptoms present)

O Depressed mood	**O** Loss of interest	**O** Crying spells
O Racing thoughts	**O** Hallucinations	**O** Self harm
O Excessive worry	**O** Forgetfulness	**O** Increased irritability
O Unable to enjoy activities	**O** Concentration problems	**O** Fatigue
O Impulsivity	**O** Sleep disturbances	**O** Anger outbursts
O Anxiety/anxiety attacks	**O** Suspiciousness	**O** Suicidal Thoughts/Plans
O Sleep pattern disturbance	**O** Change in appetite	**O** Mood changes
O Increase risky behavior	**O** Excessive energy	**O** Social/School Problems
O Avoidance	**O** Excessive guilt	**O** Parent/Child Conflict

Previous Mental Health Diagnosis, if applicable:

_____

_____

Have you ever been psychiatrically hospitalized? **O** Yes **O** No

If yes, describe for what reason, when and where:

_____

_____

List all current medications and prescribing physician:

_____

_____

Do you have any allergies or medical conditions we should be aware of?

_____

Freehold Child Diagnostic Center, Inc.

Patient Intake Form 2/3

Are you currently in psychotherapy/counseling? If so, please give name and phone # of therapist:

_____

List any school-related difficulties/accommodations received:

_____

_____

Have you ever been treated for alcohol or drug use or abuse? **O** Yes **O** No

If Yes, for which substances and what was the length of use?

_____

_____

Do you have any pending legal problems? **O** Yes **O** No

List any birth complications or developmental concerns:

_____

List the individuals you currently reside with:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are there any issues regarding custody, guardianship or visitation that we should be aware of: **O** Yes **O** No

If yes, describe: _____

***Please Note that FCDC will not get involved with any custody/ divorce issues. The evaluation is not intended, nor is it appropriate for, legal deliberations (i.e. divorce, child custody, visitation, child support or other non-educational/non-clinical matters).**

Has anyone in your family been diagnosed with or treated for mental health difficulties:

_____

_____

_____

Have you or a member of your family been treated by Freehold Child Diagnostic Center, Inc.? **O** Yes **O** No

If yes, please specify: _____

Freehold Child Diagnostic Center, Inc.

Patient Intake Form 3/3

Any additional comments or information that would be helpful to us?

_____

_____

_____

_____

_____

Pharmacy Information:

Pharmacy Name: _____

Phone Number: _____

Town: _____

Best Phone Number to be reached by Prescriber/ Therapist: __(____)_____

Emergency Contact(s):

Name: _____ Relationship _____

Phone: _____ Email: _____

Name: _____ Relationship _____

Phone: _____ Email: _____

Signature of Person Completing Form/ Relationship and Date:

_____

Signature **Relationship** **Date**

Freehold Child Diagnostic Center, Inc.

SAJJAD A. ZAIDI, M.D. & ASSOCIATES

Diplomate: American Board of Psychiatry & Neurology
In the Specialty of Psychiatry & Medical Subspecialty of Child & Adolescent Psychiatry
Diplomate: American Board of Addiction Medicine

Megan Maroney, Pharm.D. | Barbara Scarano, DNP | Rachel Karbowski, APN | Laura Loray, APN
Kristina Pilgrim, LCSW | Brad Morder, LPC | Victoria Tancsak, LPC | Jessica DeLuca, LPC

www.psychiatricdiagnosticcenter.com

501 Iron Bridge Road, Suite #6
Freehold, NJ 07728
Ph: 732-761-1900
Fax: 732-761-2388

2100 Corlies Ave, Suite 14
Neptune City, NJ 07753
Ph: 732-775-9900
Fax: 732-775-9909

Acknowledgement of Office Policy

Compliance with appointments is the key to successful evaluations and therapy sessions. **If you fail to show for your appointment or you cancel/no show without 24 hours' notice, you will be charged for your session in full**. This fee will be payable by you and cannot be processed through your insurance company. Reminders are sent via email one week and one day prior to appointment to ensure that Freehold Child Diagnostic has allotted that date and time specifically for you. As we have an extensive wait list it is a courtesy to our Associates and other patients to be sure to show up for your appointment or cancel within 24 hours. Please confirm that your email and credit card information is updated, if you have any changes please notify the front desk staff and they will happy to assist you. **The fee for missed appointments will be charged to the credit card on file**. If missed appointments are not paid in full, future appointments will not be made until all outstanding balances are paid in full.

We do not accept insurances; therefore, we are considered out of network providers. Payment is due in full at the time of each session. You will receive a receipt to submit to your insurance company should you have out of network benefits and may be able to be reimbursed. The cost of appointments varies per services. It is your sole responsibility to know your insurance benefits as we cannot guarantee that they will reimburse you and at what rate. A $25 return check fee will be assessed for any checks that are returned by your bank.

I have read and agree to all of the above statements regarding the office policies/procedures at Freehold Child Diagnostic Center.

Patient Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship to Patient:** _____