Priti M Kothari, M.D., P.A.
5550 GLADES ROAD
SUITE304
BOCARATON, FL33431
TEL: 561-483-0844
FAX: 561-235-7884
admin@pmkothari.com

## PATIENT INFORMATION

Patient Name: _____Today's Date: _____DOB:_____

Patient Address:_____City:_____State:_____Zip:_____

Male ( ) Female ( ) Other ( )

Parent/s (if patient is a minor): _____Patient's Occupation:_____

Home Phone:_____Voicemail, Ok? ( )

Cell Phone:_____Voicemail, Ok? ( )

Email:_____

Patient Status: Single ( ) Married ( ) Divorced ( ) Widow/er ( ) Other ( )

Referred by:_____Patient's Physician:_____

If patient is a child/minor, School Name:_____Grade:_____Teacher: _____

Current Medication & Dosages:_____

Family members living with patient (Name, Relationship & Age):_____

Purpose of Visit:_____

History of Presenting Problem:_____

Psychiatric/Psychological treatment history:_____

**Signature or Consent for Treatment: Responsible Party**
**PARENTS NEED TO SIGN**

Name:_____Male ( ) Female( )

Address:_____

Cell Phone: _____Home Phone: _____Email:_____

Signature of consent for treatment of Minor: _____

## PATIENT FINANCIAL AGREEMENT

This Patient Financial Agreement (the Agreement) is made and entered into on this ___day of _____, 20 ____ by and between:

Provider: DR. PRITI KOTHARI, M.D. P.A.
5550 Glades Road Suite 304, Boca Raton, FL 33431
Ph# 561-483-0844
admin@pmkothari.com

Patient & Guardian Name: _____ DOB: _____

**1. Agreement to Enter Psychiatry Services.** I am choosing to enter psychiatry services with Priti M. Kothari, M.D., P.A., I agree that my appointment time is reserved exclusively for me, and I agree to be responsible for the FULL APPOINTMENT FEE if I fail to cancel a scheduled appointment at least 24 hours in advance..

**2. Initial Fees & Deposit.** The total cost for initial services is **$700.00 (Total Initial Fees)**. The patient agreed to pay a NON**-REFUNDABLE DEPOSIT** of $200 at the time of booking or prior to the first appointment. The remaining balance of $500 **MUST BE PAID AT THE TIME OR BEFORE THE INITIAL APPOINTMENT.**

**3. Follow-Up Appointment Fee.** Follow-up appointments, whether conducted in-office, phone consultation, Zoom, or FaceTime, will be billed at **$295 per session**. All follow-up appointment fees are **DUE AT THE TIME OF SERVICE** unless prior arrangements have been made.

**4. Appointments of 45 minutes.** Follow-up appointments of 45 minutes, whether conducted in-office, phone consultation, Zoom, or FaceTime, will be billed at **$550 per session**.

**5. Forensic Psychiatry Fee.** Forensic Psychiatry appointments, whether conducted in-office, phone consultation, Zoom, or FaceTime, will be billed at **$900 per session**.

**6. Payment Terms & Late Fees**. Payments must be made via **[Cash, Credit Card, Check, etc.].** Any balance overdue by more than **30 days** will incur a **$50 late fee**. If a balance remains unpaid beyond the agreed-upon time, the Provider reserves the right to send the outstanding balance to a collection agency or pursue legal action, including court proceeding. If legal action is required to collect unpaid fees, the Patient agreed to be responsible for all collection costs, court fees, and attorney fees incurred by the Provider.

**7. Cancellation & Deposit Refund Policy** – The deposit is **REFUNDABLE ONLY** if the appointment is cancelled **AT LEAST 24 HRS** in advance. If the appointment is canceled **LESS THAN 24 HRS**, the deposit is non-refundable. If the Provider cancels the appointment, the deposit will be fully refunded or applied to a rescheduled appointment at the Patient's request.

**8. Acknowledgement & Agreement**
By signing below, the Patient acknowledges and agrees to the financial terms outlined in this Agreement, including payment responsibilities, late fees, and potential legal consequences for non-payment.

**DR. PRITI KOTHARI, M.D. P.A.**
**Patient Signature:**
**Patient/Guardian Signature: _____ Date: _____**

**Priti M Kothari, M.D., P.A.**
**5550 GLADES ROAD**
**SUITE304**
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# CREDIT CARD PAYMENT AUTHORIZATION

**Patient Name:** _____

authorizes Dr.Priti Kothari, to charge the following card for each office visit.

Amount to be charged: **$**_____**INITIALFEES**- A deposit of $700 will be collected at the time the appointment is scheduled, which will be applied towards the initial visit. If the appointment is cancelled or rescheduled with 24HRS notice, the deposit will be refunded.

**$**_____**FOLLOW UP FEES**- All payments should be made before or during the visit.

**$**_____**NO SHOW FEES-** Any missed appointments will be a full follow-up charge, unless 24 hours advanced notice is provided.

**CARD DETAILS:**

[ ] VISA [ ] MASTERCARD [ ] DISCOVER [ ] AMERICANEXPRESS

Cardholder Name: _____

Account/ CC Number: _____

Expiration: _____CVC: _____Zip Code: _____

I agree/understand that this authorization will remain in effect until I cancel, and I agree to notify of any changes. I acknowledge that the authorization of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card.

**Signature:** _____**Date:** _____

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Information about patients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases, the name of the patient, or any identifying information, is not disclosed. Clinical information about the patient is discussed.

In some cases, notes and reports are dictated/typed within the practice or by outside sources specializing (and held accountable) for such procedures. When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. This information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries and (g) information that has been requested to be separate. The material disclosed in conjoint family or couples' sessions, in which each party discloses such information in each other's presence is kept in each file in the form of case notes.

**One Effort We Make to Ensure Your Confidentiality Is in Leaving Phone Messages:**

In the event in which the practice or mental health professional must PHONE/TEXT the patient for purposes such as appointment cancellations or reminders or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the practice or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below), we will adhere to the following procedures when making phone calls: First we will ask to speak to the patient/guardian without identifying the name of the practice. If the person answering the phone asks for more identifying information, we will say that it is Dr. Kothari's office calling and asking for a call back as appropriate. If we reach a voicemail, we will follow the same guidelines.

**PLEASE CHECK PLACES WHERE YOU CAN BE REACHED BY PHONE**

Include phone numbers and how you would like us to identify ourselves when phoning you.

Home:_____May we say practice name, If not then what? _____

Cell: _____May we say practice name, If not then what? _____

Work: _____May we say practice name, If not then what? _____

I agree with the above limits of confidentiality and understand their meanings and ramifications.

**Patient's Name (print): _____**

**Patient's (or Guardian's) Signature: _____Date: _____**

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## Pharmacy Policy

Due to the heavy volume of incoming pharmacy faxes, Dr. Kothari requires patients or authorized family member/s (consent on file), call for medication refills. Our office will not respond to pharmacy refill requests as many of these faxes are on auto refill and are not patient generated. Patient and/or authorized family member/s agree to call the office and not the pharmacy for refills. We require a 72-hour notice for prescription refills and prior authorizations.

Initial: _____

Preferred Pharmacy Name: _____

Address: _____

Phone: _____

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# LIMITS OF CONFIDENTIALITY

The contents of an intake or assessment session are considered confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the patient or the patient's legal guardian. It is the policy of this practice not to release any information or written records about a client with another party without the written prior consent of the patient, without a signed release of information.

There are times we have a legal obligation to release information, which include the following:

**1. Duty to Warn and Protect**
When a client discloses intention or a plan to harm another person, the healthcare professional is required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

**2. Abuse of Children and Vulnerable Adults**
If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult) or a child (or vulnerable adult) is in danger of abuse, the healthcare professional is required to report this information to the appropriate social service and/or legal authorities.

**3. In the Event of a Patient's Death**
In the event of a patient's death, the spouse or parents of a deceased patient have a right to access their spouse or child's records.

**4. Professional Misconduct**
Health care professionals are required to report professional misconduct by a health care professional. In cases in which a professional or legal disciplinary meeting is being held regarding the healthcare professional's actions, related records may be released in order to substantiate disciplinary concerns.

**5. Court Order**
Healthcare professionals are required to release records of clients when a court order has been placed.

**6. Minors/Guardianship**
Parents or legal guardians of non-emancipated minor patients have the right to access the patient's records.

**7. Other Reasons Information May Be Released**
By choosing to use your insurance for psychiatric services, we are required to release certain information to the insurance company at their request. Information which may be requested includes the following: type of services, dates/time of services, treatment plan, and description of impairment, case notes and summaries.

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If debt remains unpaid it may be reported to credit agencies and the client's credit report may state the amount owed, time, and the name of the practice.

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient Name:_____DOB: _____

Address: _____

Phone: _____

By signing this authorization, I authorize Dr. Priti Kothari to use and/or disclose certain protected health information (PHI) about:

**Patient's Name**, _____to

Name of Individual/Group/Agency/Hospital/etc.: _____

Address: _____

Phone/ Fax:_____

This authorization permits Dr. Kothari, M.D., to use and/or disclose to or obtain from other designated party listed above, specified individually identifiable health information about the above named patient including but not limited to medical records, reports, and progress notes related to diagnoses, comprehensive medical history, drug and alcohol abuse history and treatment, legal history, HIV status and /or treatment, history of sexually transmitted diseases, treatment plan, and prognosis. Additional information may include the following: laboratory and imaging results, report cards, progress reports, educational testing, direct interview, and any other information deemed appropriate by the specified individuals contacted and/or Dr. Kothari.

The information will be used or disclosed for the continuity of care, diagnosis, and direct treatment planning; The purposes are provided so that we can make an informed decision whether to allow a release of the information.

This authorization will only expire by written consent or formal termination of treatment. The written revocation must be submitted directly to Dr. Priti Kothari.

I do not have to sign this authorization in order to receive treatment from Dr. Priti Kothari. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. My signature on this Authorization indicates that I am giving permission to the uses and disclosures of the protected health information described above. I hereby release Priti M. Kothari, M.D. from any and all liability that may arise from the release of information as I have directed.

Signature of Patient or Legal Guardian: _____

Relationship to Patient: _____Date: _____

Witness: _____Date: _____

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## Patient Authorization for Text Message Communication

Patient Name: _____
Date of Birth: _____
Mobile Number:_____
Email (optional):_____

**Healthcare Provider Name: Dr. Priti Kothari M.D. P.A.**

**Authorization for Text Message Communication**

I, [_____],authorize [**Dr. Priti Kothari M.D. P.A.]** to send text(SMS) messages to my provided phone number for the purposes of:

**☑Appointment reminders**
**☑Appointment cancellations**
**☑Rescheduling notifications**
**☑Other healthcare-related communications (e.g., prescription updates, billing notices)**

**The SMS consent language on your form must read: "I consent to receive SMS from [Dr.Priti Kothar iM.D. P.A.]. Reply STOP to opt-out; Reply HELP for support; Message & data rates may apply; Messaging frequency may vary. Visit [https://www.drpritikothari.com/privacy/] to see our privacy policy and Terms of Service."**

I understand that:

- Standard text messaging rates may apply as determined by my mobile carrier.
- Text messages are not a secure form of communication and may be intercepted or read by unauthorized parties.
- My information will not be shared with any third party for marketing purposes.
- I am responsible for notifying [DR. PRITI KOTHARI M.D. P.A.] if my phone number changes or if I wish to withdraw this authorization.
- I may opt out of receiving text messages at any time by replying STOP to any message received or by contacting [Dr. Priti Kothari office 561-483-0844].

By signing below, I acknowledge that I have read and understood this authorization and consent to receive appointment-related text messages from [Healthcare Provider/Practice Name].

**Patient/Guardian Signature: _____Date: _____**

**Office Use Only**
**☑Authorization recorded in the patient file**
**☑Opt-out instructions provided**