

Vik Shukla, MD
Child, Adolescent & Adult Psychiatry Services
839 Majestic Ct. Unit 8
Gastonia, NC 28054

PATIENT INFORMATION

**** Please complete all questions ****

Only Legal Guardians may sign for patients and must present legal documentation

Minors under 18 years of age may not sign these forms

Date _____ Social Security Number _____

Name _____
First Middle Last

Address _____

City _____ State _____ Zip _____ County _____

Date of Birth _____ Age _____ Race _____ Ethnicity _____

Phone (Home) _____ Phone (Cell) _____ Phone (Work) _____

Sex M F Single Married Other Language Preference _____

EMAIL ADDRESS: _____

Primary Care Physician Office: _____ PH: _____

Primary Care Address: _____

Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Allergies : _____

Have ever seen another mental health provider? Yes or No

List the Names:

No Show Policy

It is our policy that patients who “No Show” for scheduled appointments or cancel **without 24 hour prior notice, will now be billed a \$90.00 fee.** If you cannot reach the office during regular business hours, you may leave a message on the voice mail.

704.868.8988 or 704868.8888

Signature: _____ **Date:** _____

Relationship to patient (if applicable): _____

Grievance Policy

Vikram Shukla’s mission urges us to emphasize human dignity and social justice as we move toward the creation of a healthier community. Respect for human dignity includes respecting your rights as a patient in our office.

If you feel that any of your rights may have been violated, you may initiate a formal grievance. You may notify the Office Manager in writing at Vikram R. Shukla, MD, Attention: Office Manager, 839 Majestic Ct., Suite 8, Gastonia, NC 28054. You may also call and speak with the Office Manager: The telephone number is 704-868-8988.

The Office Manager will contact you upon the receipt of the grievance and will investigate the complaint. Every effort will be made to respond to Patient Grievances within 7 days. If the complaint will not be resolved, or if the investigation is not or will not be completed within 7 days, an update will be given to the patient or the patient’s representative informing them that the Office Manager is continuing to resolve and investigate the complaint. This letter will also have the names of the contact person for any further correspondence.

You also have the right to file a complaint with:

Your health insurance carrier (refer to your health insurance carrier for their grievance policy)

Patient/Legal Guardian Signature: _____ **Date** _____

Patient or Responsible Party Signature that they understand patient rights.

Our pledge regarding medical information:

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. The *Notice of Privacy Practices* will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. This is also posted in our lobby for your convenience.

I have been given and/or read a *Notice of Privacy Practices*

Patient/Legal Guardian Signature: _____ **Date** _____

Patient or Responsible Party Signature that they understand patient rights.

Medication Consent Form

Vik Shukla, MD (name of provider prescribing medications) has educated me regarding the medication(s) that has been prescribed to (please check one of the following) ____, 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(s), 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(s) was prescribed.

Print Patient's Name: _____

Patient/Legal Guardian Signature: _____ **Date** _____

Provider's Signature: _____ Vikram R. Shukla, MD Date: _____

- It is recommended that women who are or may be pregnant, or are breast feeding discuss this with their doctor **before** taking **any** medications.
- 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. Does the patient have food or medication allergies?
 3. What are the patient's medical conditions?

INFORMED CONSENT FOR TREATMENT

I, _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by Vikram Shukla, MD behavioral health provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of provider's license, certification and training of the behavioral health care provider directly supervising the services received by the patient.

I have been informed of risks, benefits of my treatment including any medication/medications, alternative methods of treatment, and consequences of no treatment.

If the patient is under the age of 18 years or unable to consent to treatment, I attest that I have legal custody of the individual and I am authorized to initiate and consent for the treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature: _____ **Date:** _____

Relationship to patient (if applicable): _____

You do not have to complete all 3 sections. You only list whom you want as: only an emergency contact, to have access to your information/ appointments / account or if they are simply the policy holder on your insurance and you don't permit them access to your information other than account dealings with insurance. Examples of these situations would apply to divorced parents but one carries insurance on the child/spouse, married and wants spouse as emergency contact but not information about themselves, unmarried parents with different last names, single parents with family members that help out and even disabled patients with family members but they also have a care giver they wish to grant privileges.

Emergency Contact / HIPAA Shared Information / Policy Holder Information

Circle all that apply : Emergency Contact / HIPAA Shared information Contact / Policy Holder Info

Name: _____ Phone _____

Relationship to the patient: _____ Date of Birth _____ M ___ F ___

Address: _____

Patient Signature of release of information: _____ Date _____

Emergency Contact / HIPAA Shared Information / Policy Holder Information

Circle all that apply : Emergency Contact / HIPAA Shared information Contact / Policy Holder Info

Name: _____ Phone _____

Relationship to the patient: _____ Date of Birth _____ M ___ F ___

Address: _____

Patient Signature of release of information: _____ Date _____

Emergency Contact / HIPAA Shared Information / Policy Holder Information

Circle all that apply : Emergency Contact / HIPAA Shared information Contact / Policy Holder Info

Name: _____ Phone _____

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Address: _____

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