Kamal Jajodia, MD
1360 Beverly Road, Suite 203, McLean, VA 22102

REGISTRATION INFORMATION

E-mail address _____

(PLEASE PRINT)

cell phone _____

Date_____ Home Phone_____

Patient_____
Last Name First Name Initial

Responsible Party (if a minor)_____

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Full-Time Student ☐ Part-Time Student Patient's School Name_____

Patient Employed By_____

Business Address_____

Occupation_____ Business Phone_____

Spouse (or responsible party) Name_____ Birthdate_____

Business Name and Address_____

Occupation_____ Business Phone_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security #_____ Spouse's Social Security #_____

Please list other doctors you have seen in the past 5 years:

1._____ City/State_____
(General Practitioner, Specialist, or other)

Reason for seeing_____

2._____ City/State_____
(General Practitioner, Specialist, or other)

Reason for seeing_____

How did you learn of our practice?_____

Whom may we thank for referring you?_____

In case of emergency, who should be notified?_____

Phone_____ Relationship to patient_____

(OVER)

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononeucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking	**ALLERGIES** To medications or substances
Pharmacy Name_____ Phone_____	

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date

Kamal Jajodia, MD
1360 Beverly Road, Suite 203, McLean, VA 22101

Please carefully read the following office policies. If any questions arise please do not hesitate to ask for clarification.

Insurance

I do not accept insurance, including medicare. I will provide an invoice that can be presented to the insurance companies for reimbursement.

Appointment Cancellation Policy

In a psychiatric practice, a large block of time is reserved for you, and often that slot cannot be filled on a short notice. Therefore, **missed appointments and appointments cancelled less than 48 hours in advance will be charged at the full rate.** However, in case of a serious emergency or unexpected illness, there will be no charge.

Appointment Reminders

Reminders via phone or text are a courtesy; however, patients are responsible for keeping their appointments.

Prescription Refills

Prescriptions and medication refills will be provided during the appointments. Stimulants and other controlled substances cannot be called in or faxed to a pharmacy. If medication needs to be refilled outside an appointment, please ask your pharmacy to contact me. **Please give at least 48 hour notice for prescription refills.**

Fees

- Initial Psychiatric Evaluation (60 mins) $350
- Medication plus Psychotherapy (50 mins) $275
- Medication Management (20-25 mins) $175
- Phone Visit (20-25 mins) $175

Medical Records Charges:

- $10.00 for 1-15 pages
- $20.00 for 16-50 pages
- $40.00 for 50+ pages

I have read and understand all

Signature:_____ Date:_____

FINANCIAL AGREEMENT

Kamal Jajodia, MD
1360 Beverly Road, Suite 203, McLean, VA 22101

Kamal Jajodia. MD has established the following financial policies in regard to fees charged for services:

1. Fees are due and payable when services are rendered, unless other agreements have been made in advance. Patients are held responsible for the hours(s) reserved for them, whether or not they use the hour, UNLESS 48 HOURS NOTICE IS GIVEN PRIOR TO THE APPOINTMENT.

2. The initial visit must be paid in full before the session.

3. If patients are using insurance, it is their responsibility to collect the fees due to Dr. Jajodia from their insurance company, unless other prior arrangements have been made. Dr. Jajodia will aid in insurance form completion and will forward pertinent information when requested.

4. Because insurance policies vary, it the patient's responsibility to confirm the percent of the fee which the policy will cover. In instances when payment of the total fee at the time of visit is not possible, you will be expected to pay the copayment that day and forward the insurance check to Dr. Jajodia when received by you. Some services provided (report writing, phone consultations, extended testing, etc.) may not be covered by your insurance company. All services rejected or denied by your insurance company as "non-covered" will be your financial responsibility and payable by you to Dr. Jajodia within 30 days of the insurance determination.

5. If an account becomes 90 days overdue, full payment will be collected by Dr. Jajodia for each visit until 90-day balance is paid.

6. A finance charge of 1% per month will accrue on any balance 120 days overdue.

7. I/We understand and agree that if neither I/we, nor our insurance carrier pay any balance to Dr. Jajodia which is overdue by more than 120 days, then Dr. Jajodia shall turn my/our account over for collection, and upon such event, I/we agree to pay to Dr. Jajodia 33.33% of the overdue balance, or such greater sum as any Court determines is fair and reasonable and for attorney's fees to reimburse Dr. Jajodia for such expense, and all Court costs incurred by Dr. Jajodia.

Signed:_____ Date:_____

PATIENT EASY PAY CONSENT FORM

Kamal Jajodia, MD
1360 Beverly Road, Suite 203, McLean, VA 22101

Please complete and return this form to our office if you would like for us to bill your Visa or MasterCard automatically for any balance owing on your account at the time of service and/or past due.

Patient Name (Print):_____ **Today's Date:** _____/_____/_____

Parent/Guardian Name (Minor patient):_____

I authorize Comprehensive Mental Health Services to charge my Visa or MasterCard credit card for any out of pocket expense which may be my responsibility until paid in full; I understand that if the charge is not accepted by the credit card company, I will immediately make payment to the practice.

I understand that I may cancel this authorization through written notice to the practice named above at any time, but by doing so I acknowledge that the balance owing will be due and payable in full.

Responsible party Signature:_____

Relationship, if not patient:_____

We accept Visa or MasterCard

Today's Date: _____/_____/_____

Cardholder Name:_____

Cardholder Mailing Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Credit Card Company Name:_____

Amount: $_____

Account Number:_____

Expiration Date:_____/_____ **Security Code** (3 digit on back of the card):_____

Cardholder Signature:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on August 1, 2016 and remains in effect until we replace it.

1. 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 practice. We need this record to provide you with quality care and comply with certain legal requirements. This notice 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.

2. OUR LEGAL DUTY

Law Requires Us to:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect.

We Have The Rights to:

- Change our privacy practices and the term of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice Of Change to Privacy Practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The followings section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. Your specific written authorization will be requested for use or disclosure purposes not listed. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our heal care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

- ***Notification:*** Medical information to notify or help notify a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. We may share information that directly relates to that person's involvement in your health care. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.
- ***Disaster Relief:*** Medical information with a public or private organization or person who can legally assist in disaster relief efforts.
- ***Research in Limited Circumstances*:** Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

- ***Funeral Director, Coroner, Medical Examiner:*** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.
- ***Specialized Government Functions:*** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for Government programs providing public benefits.
- ***Court Orders and Judicial and Administrative Proceedings:*** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement official. We may share limited information with a law enforcement official concerning the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
- ***Public Health Activities:*** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purpose of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by the law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
- ***Victims of Abuse, Neglect, or Domestic Violence:*** We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
- ***Workers Compensation:*** We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.
- ***Health Oversight Activities:*** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.
- ***Law Enforcement:*** Under circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You have a Right to:

- Look at or get copies of your medical information. This right does not apply to psychotherapy notes. You must make a request in writing and there is a charge for copying and mailing records. Please ask for a full explanation of our fee structure.
- Receive a list of all the times we shared your medical information for purpose other than treatment, payment, health care operations and other specified exceptions.
- Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in the case of emergency).
- Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to your doctor.
- Request that we change your medical information. We may dent your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate if you choose to file a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
KAMAL JAJODIA, MD

I acknowledge being offered and/or receiving a copy of the Notice of Privacy Practice of Kamal Jajodia, MD

on _____(date)

Printed name of patient _____

Printed name of authoritative representative (if applicable) _____

Signature of patient or authorized representative _____

Comments of Kamal Jajodia, M.D., regarding why written acknowledgement was not obtained

_____

_____

_____