Ridgewood Clinics

Krishan K. Gupta, M.D.
1059 Ridgewood Place
Jackson, MS 39211

(601)957-3211 (PHONE)
(601)957-9753 (FAX)
www.wedpsychmd.com

Welcome

Welcome to Ridgewood Clinics! We are pleased that you chose us to meet your mental health care needs. For over twenty years, Dr. Krishan K. Gupta and his team at Ridgewood Clinics have provided mental health care services to thousands of individuals across Mississippi. We offer a variety of services for children, adolescents, and adults. Our highly skilled and experienced clinicians are currently accepting new patients and dedicated to providing quality care to you and your family. We do have some important policies and instructions for you in this packet, so please read the following carefully.

Consent Forms and Clinic Policies – All policies of Ridgewood Clinics are available in the clinic and on our website. Our policies include important information regarding treatment, privacy, and payments. Our patients are responsible for reviewing and following all clinic policies. If there are any questions regarding this information, please ask for clarification. By signing consent forms, you voluntarily agree to treatment by providers of Ridgewood Clinics. By signing policy forms, you acknowledge you are aware of, understand, and agree to policies of Ridgewood Clinics.

Intake Packet – We ask that you please take the time to complete the following patient intake forms and bring these to your appointment. If you need assistance or have questions, please arrive 30 minutes prior to your scheduled appointment time. This includes a life history questionnaire, which is a lengthy list of questions. Some of the information requested is of a personal nature. Other than the exceptions mentioned in our privacy policy, this information is kept confidential. Also, answering these questions honestly will greatly assist us in providing the best care possible.

Please bring the following to **EVERY** appointment:

Photo ID (Patient and/or Legal Guardian)

Insurance Cards

Please bring these additional items to your **FIRST** appointment:

Patient Questionnaire (included in this packet)

Signed Consents (in this packet)

Signed Acknowledgement of Policies (in this packet)

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Payment Policy

Payment is due at the time of service. Ridgewood clinics accept cash, credit or debit cards. Most insurance plans require a deductible or copay. This amount is the client's responsibility.

Insurance Claims

Ridgewood Clinics value our patients and we are here to assist you. As a courtesy, we file your insurance claims. However, you are responsible for insuring proper payment is received from your insurance company in a timely manner. All claims not paid within 90 days, will be transferred to the patient's responsibility. Our providers often order lab work or testing that some insurance plans do not cover. You are responsible for understanding services covered through your insurance plan.

Self-Pay

If you are a self-pay patient, payment is due at the time services are rendered.

Missed Appointments

If clients miss an appointment or fail to cancel an appointment 24 hours prior the scheduled time, they will be charged the full service fee. Exceptions may be made for emergencies at the discretion of the provider. As a courtesy, we call to remind clients of their appointment. All clients are responsible for providing accurate and updated contact information.

Unpaid Accounts

Accounts not paid within 90 days will be referred to a collection agency. Once your account is placed in collections, you will be responsible for any additional fees applicable. These may include collection agency fees, legal fees, interest accrued. We reserve the right to terminate the patient-clinician relationship for accounts that are past due after 90 days. If you are having financial problems, please let us know as soon as possible. We may be able to work out a payment plan.

Reports or Professional Consultations

Any reports, professional consultations, or clerical tasks will be billed per hour. This rate will be determined based on the requested service. We will inform you of this amount at your request.

Phone Calls

We will not bill for phone calls to schedule appointments, discuss possible reactions to recently prescribed medications, follow-up calls made by us, or calls to you to discuss payment. You may be billed for phone calls during or after normal business hours to discuss other treatment matters. Due to frequently changing healthcare costs, ask about current prices before speaking with a provider.

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Privacy Policy

Any information provided during your treatment at Ridgewood Clinics, verbal and written, will be kept confidential. We will not share this protected health information. You may request for Ridgewood Clinics to send your medical records to another provider. Also, you may give Ridgewood Clinics permission to request your previous records from another provider. In order to send or receive these records, we must have the patient or patient's responsible party provide written consent. There are a few exceptions to our privacy policy. At times providers may be legally obligated to share your protected health information. This information may be discussed with others under the following circumstances:

Duty to Warn and Protect:

As licensed mental health professionals, we have a legal obligation to make efforts to protect our clients from harming themselves or others. If a client verbalizes thoughts of self-harm or a plan for suicide, providers should notify legal authorities and attempt to inform the client's family or emergency contact. If a client discloses intentions or plan to harm another person, providers are required to inform the intended victim and legal authorities.

Abuse of Vulnerable Persons:

If a provider becomes aware of or suspects abuse of a child or vulnerable adult, they are required to report this information to social services and legal authorities. This may include abuse of a client or abuse reported by a client. We also may report admitted prenatal exposure to potentially harmful controlled substances.

Parents/Legal Guardians:

Parents and legal guardians have a right to access minor clients' medical records.

Insurance Providers:

Insurance providers and/or additional third-party payers may be provided with a client's protected health information, at their request, regarding services provided through Ridgewood Clinics.

I agree to the above privacy policy. I understand the meaning of this policy and times when protected health information may be discussed with individuals other than Ridgewood Clinics' providers.

_____

Client Signature (Legal Guardian if under 18)

_____

Date

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Grievance Policy

Ridgewood Clinics' Policy is to provide an effective and timely process for any complaints. Your comfort, satisfaction, and safety are important to us. We hope to meet all of your needs at our clinic. However, if you or your family members have concerns, please let us know immediately. We will do our best to resolve any issues as soon as possible.

Who to Contact

Please contact our office regarding complaints. If the issue is unable to be resolved through telephone conversations, an appointment will be scheduled to discuss your concerns with appropriate clinic personnel. You may also submit complaints in writing and mail them to:

Ridgewood Clinics
Attn: Compliance Officer
1059 Ridgewood Place
Jackson, MS 39211

If the client or client's legal guardian feel clinic efforts to resolve concerns were unsatisfactory, they may contact:

Mississippi Board Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, MS 39216
(601) 987-3079
mboard@msbml.ms.gov

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Consent to Treatment

I, _____, do hereby voluntarily consent to care and treatment by providers of Ridgewood Clinics. Providers of Ridgewood Clinics may include psychiatrists, nurse practitioners, psychologists, social workers, counselors, or supervised interns. Treatment includes, but is not limited to, medication management, psychotherapy, individual and family counseling, and hypnosis. This consent form allows staff of Ridgewood Clinic to provide services to you. If for some reason your usual provider is unavailable, this consent allows alternative providers of the clinic to treat you as well.

Treatment at Ridgewood Clinics is always voluntary. While many individuals greatly benefit from our services, we cannot guarantee your treatment will be successful. You, or your provider, may discontinue treatment at any time deemed necessary. If at any time you wish to discontinue treatment, we encourage you to discuss your concerns with a provider. Your safety is important to us. If you so choose, we will gladly assist you in finding services elsewhere. If you have any questions or concerns regarding treatment, it is your responsibility to ask your providers. You are an active participant in treatment. If you withhold information from providers or do not clearly understand our recommendations, this could negatively impact your treatment outcome.

By signing this consent, you acknowledge that you fully understand all matters discussed in this form. You attest that you are entering treatment voluntarily. If the client is a minor, you attest that you are this client's legal guardian and you voluntarily consent for them to enter treatment. Further, you acknowledge that risks and benefits of mental health treatment have been explained to you.

_____ _____

Client Name (Print) Ridgewood Clinics Provider (Print)

_____ _____

Client Signature (Legal Guardian if under 18) Ridgewood Clinics Provider (Signature)

_____ _____

Date Date

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Controlled Substance Policy

During your treatment at Ridgewood Clinics, you may be prescribed a controlled medication. Your safety is important to us, so we want you to understand your responsibilities as a client.

Take medications only as prescribed by your provider.

Your provider will discuss risk and benefits of medications to you. If there is anything you do not understand, please ask.

We are not responsible for lost or stolen medications or prescriptions.

You must inform providers of all medications you are taking and inform them of any changes made by other providers.

Your provider may order a urine drug screen or alcohol breath test.

You should not allow anyone else to take medications prescribed to you.

If you fail to comply with this policy, your provider may discharge you from their services.

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Client's Bill of Rights

The medical staff and administration of Ridgewood Clinics are dedicated to providing clients with quality care in a manner which protects their privacy and dignity. In order to accomplish this, a set of "Client's Rights" have been identified. These "Rights" included the following:

Respect

The client has the right to considerate, respectful care and recognition of his/her personal dignity at all times and under all circumstances.

Non-Discriminatory Treatment

Clients' shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, or sources of payment for care.

Confidentiality

The patient has the right, within the law, to personal and informational privacy as manifested by the following rights:

To be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.

To expect that any discussion or consultation involving his/her case will be conducted discreetly and that individuals not directly involved in his care will not be present without his/her permission.

To have his/her medical record read only by individuals directly involved in his treatment or in the monitoring of its quality and by other individuals only on his written authorization or that of his/her legally authorized representative.

To expect all communications pertaining to his/her care to be treated as confidential information.

Personal Safety

Clients have the right to expect reasonable safety insofar as the clinic practices and environment are concerned.

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I, _____, have reviewed and fully understand all policies of Ridgewood Clinics including the following:

Payment Policy

Grievance Policy

Privacy Policy

Client's Bill of Rights

Controlled Substance Policy

_____

Signature

_____

Date

These policies are subject to change. Patients will be informed of such changes as they are made.

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Patient Information

Date _____ Account Number _____ First Name _____ Last Name _____ Middle Name _____

Social Security # _____ DL # _____ D.O.B _____ Age _____ Gender _____ Race _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____Email Address _____

Patient's Spouse or Patient's Guardian

First Name _____ Last Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____ Email Address _____

Person Responsible for Payment

First Name _____ Last Name _____ Social Security # _____

Emergency Contact Information

First Name _____ Last Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____ Email Address _____

Referral Source

How did you hear about our clinic? _____

Method of Payment and Insurance Information

How do you intend to pay for services provided by Ridgewood Clinics?

Cash Credit Card Debit Card Insurance Other _____

Insurance Information

Primary Insurance _____ _____ ID # _____ Group # _____

Address _____ City _____ State _____Zip _____ Phone _____

Subscriber Name _____ Subscriber D.O.B. _____ Subscriber SSN _____ Relationship to Patient _____

Secondary Insurance _____ ID # _____ Group # _____

Address _____ City _____ State _____ Zip _____ Phone _____

Subscriber Name _____ Subscriber D.O.B. _____ Subscriber SSN _____ Relationship to Patient _____

I, _____, attest the insurance information provided is accurate. I assign payment directly to providers of Ridgewood Clinics. I understand that I am responsible for all charges not covered through insurers. Also, in order to secure payment for services, I authorize Ridgewood Clinics to release any information necessary to insurers.

NOTE: Please notify us immediately of any changes in this information during your course of treatment.

Subscriber Signature _____ Date _____

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Child Intake Information

Please explain the reason for your child's visit.

In your own opinion, how severe are these problems?

Mild Moderate Severe

How long has this been going on?

What have you done to address this issue?

Have you previously discussed these problems with anyone? If yes, who was this?

Please circle ALL words or phrases that apply to your child

Hyper / Poor Grades / Headaches / Forgetful / Lies / Sexually Acts Out / Lazy / Clumsy / Sets Fires
Steals / Drinks Alcohol / Smokes Cigarettes / Uses Drugs / Breaks Rules or Laws / Harms Self / Anger
Appetite Problems / Hears Voices / Temper Tantrums / Destroys Property / Weight Problems
School Suspensions / Crying Spells / Wets Bed / Anxious / Difficulty Sleeping / Cruel to Animal / Sad
Easily Distracted / Nail Biting / Jealousy / Fighting / No Friends / Misses School / Breaks Curfew

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Psychiatric History

Has your child ever been treated by a mental health professional, such as a psychiatrist or counselor? If yes, please list names of providers, dates, and reason for treatment.

Has your child ever been admitted to a psychiatric hospital? If yes, what hospitals and when?

Please list any past mental health treatments or psychiatric medications. Was this treatment helpful?

Has your child ever been abused physically, emotionally, or sexually? If yes, at what age and by whom?

If your child's blood relatives have any of the following mental health diagnoses, please identify their relationship to the patient.

ADD/ADHD _____ Bipolar Disorder _____

Depression _____ Anxiety _____

Schizophrenia _____ Alcohol Abuse _____

Drug Abuse _____ PTSD _____

ODD _____

Any other emotional or behavioral problems _____

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Medical History

Primary Care Provider _____ Phone # _____

Date of last physical exam _____

HT. _____ WT. _____

Please list all other providers currently caring for your child.

List **ALL** allergies (e.g., medications, foods, etc.).

Please list **ALL** current medications (i.e., all Prescribed, Over-the-Counter, Vitamins, and Herbal Supplements).

Please list any medical problems.

Please list any previous injuries or surgeries and dates of these.

Menstrual/Reproductive History (If Applicable)

Age at first period _____

Are periods regular? Average # of Days _____

Does your daughter's mood changes with her period?

Has she ever been pregnant? If yes, how many times?

Has she ever had a miscarriage?

Has she ever had an abortion?

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Sexual History (If Applicable)

Is your child currently sexually active?

Is their sexual preference male, female, or both?

Do they have one partner or multiple partners?

Has your child ever had a sexually transmitted infection? If yes, what?

Family Medical History

If your child's blood relatives have any of the following medical problems, please identify their relationship to the patient.

Diabetes _____ High Blood Pressure _____

Heart Disease _____ Thyroid Problems _____

Stomach Problems_____ Seizure Disorders _____

Other _____

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Social and Developmental History

Birth and Childhood

Was this child born to you or adopted? If adopted, what agency was used?

Were there any pregnancy or birth complications? Were forceps used during delivery?

Was child's birth natural or by caesarean section?

Was this a premature or full term birth?

Number of pregnancies of mother _____ Number of miscarriages of mother _____

Birth Weight _____ Birth Length _____

Apgar Score _____

Identify the age your child could

Sit _____ Stand _____ Walk _____ Toilet Trained _____

Talk (word) _____ Talk (sentence) _____ Play in Groups _____

Education

Child's Current Grade _____

Has your child failed or repeated any grades or classes? If yes, please list each.

Does your child enjoy school?

How are their grades?

What type of classes are they in? For example, are they in special education or gifted classes?

Favorite Subject _____ Most Difficult Subject _____

Have they ever been tested for learning disabilities? If yes, please provide details.

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Environment

Who does this child currently live with? Please list all household members and their relationship to the child.

Describe the current residence (e.g., house, apartment, hotel, etc.).

Have there been any major changes or traumatic events in your family (e.g., divorce, death, abuse)? If yes, please explain.

Legal

Has your child ever had any legal problems (e.g., arrested or involved in youth court)? If yes, please explain.

Has your child and/or family ever been investigated or received intervention services by the Department of Human Services (DHS)? If yes, please explain.