

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

Patient'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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Explanation of Treatment for Opioid Dependence

Explanation of First Visit

This is usually your longest visit. Please plan to stay 1 to 4 hours. If possible, you should make your appointment in the morning.

You should arrive to your appointment already experiencing moderate opioid withdrawal symptoms. Medications prescribed will lessen these symptoms. However, if opioids are already in your system, your withdrawal symptoms may worsen.

Prior to Appointment

**no methadone or long-acting pain killers for at least 24 hours

**no heroin or short-acting pain-killers for at least 4 to 6 hours

If your provider chooses to prescribe maintenance medications, these may cause drowsiness and slowed reaction times. You should make arrangements for a ride home.

You may not want to return to work after this visit, so plan accordingly.

Bring ALL medications with you to your appointment.

ALL paperwork must be completed prior to seeing your provider. If you have not done this, arrive to your appointment 30 minutes early to complete patient forms.

Be prepared to provide a urine sample for a urine drug screen.

Your provider may order an alcohol breath test and/or blood work.

Your provider may recommend a complete physical exam by your primary care provider.

Your provider will perform a substance dependence assessment and mental status evaluation.

Your provider will discuss maintenance medication with you and your expectations for treatment.

If maintenance medication for opioid dependence is ordered, your first dose will be administered in the clinic. Your provider may have you fill your prescription at the pharmacy and return to the clinic for medication administration and observation. You should feel better within 30 minutes of your first dose. Be honest about how you feel, so your provider can determine the most appropriate dose. If a prescription is given to you, medication must be taken exactly as prescribed.

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When you leave the clinic, your provider may write a prescription that will last until your next appointment. Appointments may be monthly, weekly, or more frequent.

Your provider may recommend counseling sessions to increase your likelihood of a good outcome.

Follow-Up Appointments

Payment is due at the time of each visit as discussed in our payment policy.

Bring ALL medications and inform your provider of any medication changes.

Always be prepared to provide a urine sample for a drug screen.

Your provider may order an alcohol breath test and/or blood work.

Print out the online withdrawal questionnaire available on our website. Complete and bring this form to each follow-up appointment.

Frequency of follow-up visits will be determined by your provider as treatment progresses. These may be monthly, weekly, or more frequent based on individual needs and safety concerns.

Your provider may discharge you from this program at any time for noncompliance with recommendations or if treatment progress is ineffective.

Your provider will discuss with you and decide on the most appropriate time to begin slowly tapering and discontinuing your maintenance medication.

Your provider and/or counselor will develop and discuss a relapse management plan with you.

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Opioid Dependence Treatment Consent

I, _____, acknowledge that I fully understand all matters discussed in the
(print name) explanation of treatment for
opioid dependence form. I attest that I am entering treatment voluntarily. I understand the possibility
of discharge from treatment for noncompliance with provider recommendations or for ineffective
progress towards treatment goals. I acknowledge that risks and benefits of treatment for opioid
dependence have been explained. I have reviewed patient education forms regarding treatment with
Suboxone* (buprenorphine/naloxone) and Subutex* (buprenorphine) and understand the risks and
benefits of these medications.

Patient Signature _____

Date _____

(Suboxone and Subutex are registered trademarks of Reckitt Benckiser Pharmaceuticals, Inc.)

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Opioid Dependence Intake Information

In your own words, please explain the reason for your visit and when these problems began.

In your own opinion, how severe are these problems?

Mild

Moderate

Severe

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

Briefly describe yourself.

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Please circle ALL words or phrases that apply to you

Difficulty Sleeping / Sad or Depressed / Chest Pain or Racing Heart / Confident
Uncontrollable Emotions / Suicidal Thoughts / Homicidal Thoughts / Nausea or Vomiting / Worrier
Low Energy / Racing Thoughts / Headaches / Dizziness / Shortness of Breath / Perfectionist
Increased Energy / Anxious / Chills or Hot Flashes / Feeling Empty / Appetite Problems / Fearful
Nightmares or Flashbacks / Hallucinations / Stressed / Powerful / Reckless / Feeling Guilty / Helpless /
Hopeless / Forgetful / Goal-Oriented / Intelligent / Angry / Irritable / Physical Aggression / Outcast
Mistreated / Unorganized / Anxious / Worthless / Tense / Job Problems / Family Problems

Complete the following sentences.

I am _____

I feel _____

I think _____

I wish _____

My fears are _____

I get anxious when _____

I get angry when _____

I am able to calm down when _____

My hobbies are _____

I am interested in _____

If people know the "real me," they _____

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Psychiatric History

Have you 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.

Have you ever been admitted to a psychiatric hospital? If yes, what hospitals and when?

Please list any past mental health treatments or medications, including ECT. Were these treatments helpful?

Have you ever been abused physically, emotionally, or sexually? If yes, at what age and by whom?

If your 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 you.

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

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

Please list any medical problems (e.g., high blood pressure, diabetes, etc.).

Please list any previous injuries and surgeries dates of these.

Describe your health during childhood and adolescence, including illnesses.

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Sleep History

Do you have problems with sleep? If yes, please explain.

Are you excessively tired or sleepy during the day?

Has anyone ever told you that you snore during sleep?

Have you ever had a sleep study?

Menstrual/Reproductive History (If Applicable)

Age at first period _____

Date of last period _____

Are your periods regular? Average # of Days _____

Does your mood changes with your period?

Have you ever been pregnant? If yes, how many times?

Have you ever had a miscarriage?

Have you ever had an abortion?

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Sexual History

Are you currently sexually active?

If yes, is your current sexual relationship satisfying?

Is your sexual preference male, female, or both?

Do you have one partner or multiple partners?

Do you have any concerns or problems related to sex or masturbation? For example, do you ever feel anxious or guilty?

Have you ever been told you had a sexually transmitted infection or disease? If yes, what?

Family Medical History

If your 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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Drug and Alcohol Information

Do you use tobacco?

If yes, what kind of tobacco (e.g., cigarettes, cigars, or smokeless tobacco)?

How often? How much?When did you start?

Do you drink alcohol?

If yes, what kind of alcohol (e.g., beer, wine, or liquor)?

How often? How much?When did you start?

Do you use any other drugs?

If yes, what kind of drugs (e.g., marijuana, cocaine, prescription medications, etc.)?

How often? How much?When did you start?

In your opinion, is drug or alcohol use a problem for you?

Have you ever had personal or legal problems related to drug or alcohol use (e.g., DUIs, divorce, etc.)?

Do other people feel drug or alcohol use is a problem for you?

Have you ever been in treatment for drug or alcohol use (e.g., AA or a rehab facility)? If yes, please describe treatment and provide dates of treatment.

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Social and Developmental History

Childhood and Adolescence

Where were you born?

Were you adopted?

Do you know if your mother experienced any complications during pregnancy or childbirth?

Were you raised by your parents? If not, who raised you?

Briefly describe your childhood. For example, was this a happy time and how was your relationship with your family?

Describe your parents' relationship with each other.

Did you have step-parents? If yes, describe your relationship with them.

How were you and your siblings disciplined?

Circle any of the following that applied to you.

Bedwetting	Thumb-sucking	Nail-biting	Sleep-walking
Nightmares	Speech Problems	Fire-setting	

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Education

Did you enjoy school?

Did you make friends easily?

Were you ever bullied or teased?

How were your grades?

What type of classes were you in? For example, were you in special education or gifted classes?

Did you ever repeat any grades? If yes, which grades?

What were your strengths and weaknesses in school?

Did you graduate from high school? If not, what was the last grade you completed?

Did you attend or graduate from college? If yes, please provide details.

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Work/Income

Are you currently employed? If yes, describe your job. If not, what is your source of income?

Are you satisfied with your job?

What types of jobs have you had in the past?

Is your current income enough to meet your needs?

Do you have any financial problems?

What were your past professional goals?

What are your current professional goals?

Environment

Who do you currently live with? Please list all household members and their relationship to you.

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

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Intimate Relationships

What is your current relationship status?

Single Married Engaged Divorced Separated
Widowed Remarried Other _____

If you are in a committed relationship, how long have you been together?

Have you been married more than once? If yes, please provide dates of marriages and length of time you stayed married.

If divorced, how many times and for what reason?

Briefly describe your relationship with your spouse or partner.

How would your spouse or partner describe you?

What is your partner's occupation?

Do you get along with your partner's family?

Has anyone else interfered in your relationship or your family affairs?

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Family Relationships

Mother

Is she living or deceased? If deceased, what was her cause of death and how old were you at that time?

What was her occupation?

How was her health?

Describe her personality and attitude towards you.

Describe your current relationship.

Father

Is he living or deceased? If deceased, what was his cause of death and how old were you at that time?

What was his occupation?

How was his health?

Describe his personality and attitude towards you.

Describe your current relationship.

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Siblings

Please list names and ages of your siblings.

Describe your current relationship with your siblings.

Children

If you have children, please list each child's gender, age, and identify any specific problems.

If you have children, describe your current relationship with them.

Friendships

Do you have any close friends?

Do you make friends easily?

Do you maintain friendships over time?

Describe your relationships with friends.

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Legal

Have you ever had any legal problems? If yes, please explain.

Have you have been arrested? If yes, please explain.

Religious Background

What is your current religious preference?

Did you grow up with these religious beliefs or have they changed?

Treatment Plan

What are your goals for treatment at Ridgewood Clinics?

Is there any additional information you would like us to know?