DIRECTIONS

NeuroPsychiatry Center
Ravi Kant, MD
www.drkant.com

300 Old Pond Road, Suite 201
Bridgeville, PA 15017
BUILDING 300 (Abele Business Park)

Phone: (412) 220-7323
Fax: (412) 220-7325

FROM CRANBERRY/PITTSBURGH:

Take I-79 South (towards Washington).

Head South to exit 54 (Bridgeville).

FROM WASHINGTON/UNIONTOWN/WHEELING:

Take I-70 to I-79 North (towards Pittsburgh).

Head North to exit 54 (Bridgeville).

********Take Exit 54 (Bridgeville) ********

After the EXIT: -
From the ramp go **LEFT** onto **Route 50 West**. (Towards Cecil)

Turn **LEFT** onto **Hickory Grade Road**.

Take the first **LEFT** onto **Old Pond Road** (before the Knights Inn).

Go for about 250 yards (pass Hampton Inn) and make next **RIGHT** into **Abele Business Park**.

First building on the **LEFT** is **Building 300; Suite 201**.

FROM CENTURY III:

Take **Bethel Church Road** from Rt. 51. Then make **RIGHT** on Route 88 and **LEFT** on **Connor Road** towards Route 19 and keep going past the Galleria Mall. Road name changes to **Painters Run Road**.

Make Left on **Bower Hill Road** in Bridgeville, make **LEFT** on **Route 50 West**. Make **RIGHT** towards I-79.

Go for about ½ mile, and make **LEFT** on **Hickory Grade Rd** after going under I-79 overpass.

Take the first **LEFT** onto **Old Pond Road** Go for about 300 yards (passed Hampton Inn) and make next **RIGHT** into Abele Business Park. First building on the **LEFT** is **Building 300; Suite 201.**

PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT TIME!

RAVI KANT, MD, P.C.
NeuroPsychiatry Center
300 Old Pond Road, Suite 201, Bridgeville, PA 15017

REGISTRATION AND ASSIGNMENT/RELEASE/CONSENT TO TREATMENT

Patient ____
Last Name First Name Middle Initial

Street address ____

City ____ **State** ________ **Zip** ______________________

Phone #: Home- ____________________ **Work-** _____________________ **Cell-** ______________________

Gender: □ M □ F Age: ______________ **Birth Date** __________________ **□ Single □ Married □ Divorced □ Other**

E-mail ____

Race: □ White □ Black □ Asian □ Other _______ **Ethnicity** ____________ **Preferred Language** __________

Patient Employed By _____________________________________ **Phone #** ___________________________

Emergency contact __________________ **Phone #** ____________________ **Relationship** ________________

Responsible Party ____
(If patient is a minor or incapacitated -Relationship to patient)(Guardian/Legal Representative may be required to attach supporting legal documentation)

Address ____
(If different from patient)

Date of Birth ________________ **Soc. Sec. #** __________________ **Phone #** ___________________________

Employed By _______________________ **Address** ____

Insurance Information

1. Primary Insurance ____

Policyholder Name __________________________ **Relationship to patient** _____________________________

Date of birth ________________ **Policy #** ___________________________ **Group #** ____________________

2. Secondary Insurance ____

Policyholder Name __________________________ **Relationship to patient** _____________________________

Date of birth ________________ **Policy #** ___________________________ **Group #** ____________________

√ **Can we leave message at your home with family member/s or on the answering machine for appointment reminders or other information – Yes ___ No ___ Signature ____________**

ASSIGNMENT/RELEASE/CONSENT TO TREATMENT

(All patients/Guardians to sign below)

I authorize and request treatment/s from **RAVI KANT, M.D**. and/or his associates to perform routine diagnostic procedures and to provide medical treatment as is medically necessary in his/their professional judgment.

I hereby authorize release of protected health information, including mental health and/or substance abuse (drug and alcohol), necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me to **RAVI KANT, M.D. PC** as indicated on the insurance claim form. I also understand that I am financially responsible for any balance not covered by my insurance carrier(s) (including but not limited to deductibles and/or co-payments) and agree to pay the full charges if payment is/are denied by my insurance carrier(s) for any reason or if no insurance coverage exists at the time of services. It is my responsibility to update any changes in insurance. I understand it is mandatory to notify the health care provider of any other party who may be responsible for payments (section 1128 B, Social Security Act and 31 U.S.C. 3801- 3812 provides penalties for withholding this information). Medicare regulations apply. I have received, read and agree with the billing policies of this office.

With my consent, Ravi Kant, M.D., his associates, and office staff can call my home and leave messages on an answering machine or with a person or e-mail me regarding appointments and contact the designated emergency contact person if needed. I may revoke my consent in writing except to the extent that the practice has already acted upon in reliance upon my prior consent. If I do not sign this consent, Ravi Kant, M.D. and his associates may decline to provide services to me. I agree with the above.

All the information provided in this Registration-Assignment/Release/Consent to Treatment is true and current.

Notice of Health Information Practices – Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review)

I have read and understood the above Notice of Health Information Practices. I recognize that this is a federal mandate that this facility must comply with.

Notice of Patient Rights and Responsibilities -

I have read and understood the Patient Rights and Responsibilities provided at the office.

(Copy is available and posted in office for your review)

Patient signature ____ Date ____________________

(If patient is a minor (age14-18), he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name ____

Responsible party signature _____________________________________ Date ___________________

(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____

(Guardian/Legal Representative may be required to attach supporting legal documentation)

Witness _________________________ Name __________________________ Date ______________

FOR MOTOR VEHICLE ACCIDENT

OR

WORKER'S COMPENSATION CASE ONLY:

Check one □ **Motor Vehicle Accident** □ **Worker's Compensation**

Insurance Carrier ____

Claims Rep Name ____________________________ **Tel #** ________________

Address ____

Date of Accident ________________________ **Claim #** ___________________

Employer ____________________________ **Phone #** ___________________
(If work related)

Have you filed a workers' compensation claim with your employer? YES NO

Is your motor vehicle insurance medical claim still open and payable? YES NO

Did you get authorization from your claim rep for this visit YES NO

Do you have an attorney? If yes, Name ____________________________________

____ ______________________

Signature **Date**

____

Print Name

OFFICE POLICIES

RAVI KANT, MD, P.C. 300 OLD POND ROAD, SUITE 201, BRIDGEVILLE, PA 15017

Patient Name ____ Date of birth ___________________________

Insurance Coverage:

Due to frequent changes in insurance coverage (benefits, exclusions, deductibles or prescription coverage, etc.), we cannot inform or advise you about your benefits. In some insurance policies, certain diagnoses are excluded, such as ADHD, Autism, Mental Retardation and related conditions. We do not routinely do the paperwork for non-formulary medicines not covered by your insurance company. You are responsible for keeping track of number of visits allowed in your plan and how many visits you have used with your therapist and MD. You will be charged for additional visits. If you do not have insurance coverage, you are responsible for the full charges. Please inquire in advance about our charges if you do not have insurance.

Payments:

It is our policy to collect all **co-payments and/or deductibles** at the time of service unless arrangements are made ahead of time. **We accept checks, cash, and debit or credit cards (Visa, MasterCard or Discover).**

A service charge of **$5.00** plus interest (1.5%/month) will be added to any outstanding balance over 30 days past due. Also, all delinquent accounts (over 90 days past due) may be turned over to a collection agency. An additional **$30.00** as a handling fee and the costs of collection (including attorneys' fees and costs) will be added to the total amount due.

Cancellation/No Show Policy:

We understand that it is not always possible to keep a scheduled appointment or give 24 hours notice of cancellation. If a pattern of same day cancellations or "no shows" develop, we reserve the right to bill you **$40.00** fee for the missed appointment time. Your insurance company is not responsible for this charge. Prescriptions may not be called in for No Show or Canceled appointments. Additionally, if there are frequent No Show appointments or non-compliance with treatments, we may choose to discharge you from the practice.

Lost Prescription Fee:

A service fee of **$20.00** will be charged to replace lost scripts. Scripts will need to be picked up from the office after payment of the fee.

Returned checks – Fee of **$40.00** will be charged for checks returned for any reason.

Fees may be changed without notice.

I have read and agree to be legally bound by the terms of this office policies including the financial responsibility provisions hereof. I understand that I am financially responsible for any amounts not covered or paid by my insurance carrier and that I am responsible for providing current insurance information and inform the office of any address and/or insurance changes.

Patient signature ____ Date _________________________
(If patient is a minor (age14-18), he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name ____

Responsible party signature ____Date _________________________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Witness ______________________________ Name _______________________________ Date __________

NeuroPsychiatry Center - Ravi Kant, MD, P.C.

300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ____ date of birth ___________, do hereby consent to and authorize to
Patient's Name (Print)
disclose health information about me and that can be identified with me from my records relating to my identity, diagnoses, prognosis, and/or treatment, which records may include information related to medical conditions, tests, mental or behavioral health, and substance abuse (drug and alcohol), and HIV-related. These records are called protected health information and are protected by federal and/or state law.

From ______________________ **Ravi Kant, MD, P.C.** ______________________
(Name and address of provider or facility releasing records)

To ____
(Name and address of provider, facility, or family member where records are being released to)

€ **I authorize both the entities named above to share the health related information related to my care.** __________
Initial

The purpose or need for this disclosure is ____

I understand that the specific types of records to be released (identify all records or all that apply) are:

All records including Psychiatric/psychological evaluation

Laboratory reports & tests Physician notes only Acupuncture Other (specify) _____________
Insurance claims and payments only (including Medicare and Medicaid)

Mental/behavioral health, substance abuse, and HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

DO NOT RELEASE: Mental or Behavioral Health (Psychiatric) HIV-Related Substance Abuse (Drug and Alcohol)

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon and that this consent will remain in force no more than **12 months** from the date of execution in order to effectuates the purposes for which it is given. I also understand that any revocation of this authorization must be in writing and sent or delivered to health care provider's office. I also understand that my decision to revoke this authorization may result in my insurance company not being able to pay for my medical care and I will be liable for payment for the services rendered.

Patient Signature ________________________________Name________________________ Date ____________
(If patient is a minor (age14-18), he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Responsible Party Signature ______________________________Name________________________ Date ______________
(Parent/Guardian/Legal Representative)

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Witness ____________________________ Name ______________________________ Date ______________________________

Concussion/head injury intake- 2015

Ravi Kant, MD, P.C.
NeuroPsychiatry Center
300 Old Pond Rd., Suite 201 Bridgeville, PA 15017

Name ______________________________ DOB ____/____/____ Age ________ yrs.
Address ______________________ City ________________ State ______ Zip ______
Tel. No-. H: ________________ Cell: ________________ E-Mail: ________________
Single / Married / Divorced / Separated / Other

You will be responsible for all payments if your Insurance co. denies payment for any reasons

Current healthcare providers	Phone Number	Fax Number	Address
Family MD-			
Other MDs-			
Therapist -			
Attorney			

Referred by ____
Can we share medical information with your PCP and referral source Y N Signature ____________________

Pharmacy you use- Name City Zip Tel#

Allergies: None Known ___ Yes ___ What?________________________________
Reaction(s) ____

Living with ______________________________ Children ________________
Current Job ________________ for how long ________ Currently working? Y N
If not working, when did you stop work - ____________
Describe in your own words your current problem(s)
____

Chief Complaints (Please circle)

Depression	Y	N	Anger	Y	N
Anxiety	Y	N	Attention/Concentration	Y	N
Mood Swings	Y	N	Drugs/Alcohol	Y	N
Memory	Y	N	Headaches	Y	N
Back/Neck Pain	Y	N	Other:		

Concussion/head injury intake- 2015

History: Date of injury:________________ Where? ____

____

What happened? ____

____

Lost Consciousness Y N How Long ______________________

Were Dazed/Confused Y N Had Seat belt On Y N

Were you Driver? Passenger? Front or Rear seat

Were you Intoxicated Y N Did you hit your head anywhere Y N

Last Memory **Before** Accident____

First Memory **After** Accident ____

Do you remember details of accident Y N

Memories ____

____

____

How much damage to the vehicle **$** ____________________

Treatments for Accident:

Treated and released from ER (where) ____

Hospitalized Y N How many days __________________________

Where ________________________________ Doctor __________________________________

Test results: (if known)

X-Rays _______________CT brain ______________MRI brain _____________EEG __________ Other ________________________

Results ____

Rehab treatments: Where: Type: How Long

Had ImPACT or Neuropsychological testing done Y N When and where

Ever suffered Concussion in the past Y N Details ______________________________

Ever had similar problems before this accident: Y N Details______________________________

Extended exposure to chemicals Y N Describe ______________________________

Current Stressors (Please circle)

School Y N Social Y N Work/Job Y N

Marital Issues Y N Family Y N Financial Y N

Pain/Disability Y N Other:

Concussion/head injury intake- 2015

Circle the appropriate answer, then rate if Y: ***(Rate symptoms on scale of 0 to 10; 0 good, 10 worse)***

Mood Swings	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Depressed	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Anxious	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Angry/Irritable	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Weight Gain or Loss	Y	N	How much (+/-) ________ lbs.
Difficulty with sleep	Y	N	Total Hours of Sleep per day ______hrs.
Nightmares	Y	N	
Fatigue	Y	N	Appetite Normal Low Increased
Feeling Worthless	Y	N	Feeling Hopeless / helpless Y N
Low Self Esteem	Y	N	Loss of Interests/ Motivation Y N
Social isolation	Y	N	Homicidal Thoughts Y N
Negative Thoughts	Y	N	
Suicidal Thoughts	Y	N	

Would you reach out to someone if you feel strongly suicidal? Y N Who? ____________________________

(You can call ER of local hospital / Suicide Hotline 1-800-273-8255 / Resolve Crisis Hotline 1-888-796-8226)

Give details of symptoms: ____

____

____

Anxiety/Panic Y N ____________How often? ____

Where? ________________________________What Triggers? ________________________________

How do you relieve these symptoms? ____

Symptoms Experienced

Dizziness	Y	N			
Palpitations	Y	N	Sweats/chills	Y	N
Bothered by crowds	Y	N	Irritable bowel symptoms	Y	N
Fear of leaving home	Y	N	Nausea	Y	N
Out of breath	Y	N	"Need to get out of the place" feeling	Y	N
Chest pressure	Y	N			
Shakes	Y	N			

Obsessions	Y	N	Describe: ________________________________
Delusions	Y	N	Describe: ________________________________
Paranoia	Y	N	Describe: ________________________________
Hallucinations	Y	N	Describe: ________________________________
Fears	Y	N	Describe: ________________________________
Flashbacks	Y	N	Describe: ________________________________

How is it affecting your family and social life? ____

____

____

Mood Swings

Has there ever been a period of time when you were not your usual self and:

You were much more talkative?	Y	N
You had much more energy?	Y	N
You were more social or outgoing than usual?	Y	N
You did things that were unusual or that other people might have thought were excessive, foolish or risky?	Y	N
You spent money or got your family into trouble?	Y	N
Quick mood changes – feeling great to crashing and feeling depressed	Y	N

Cognitive Symptoms (circle)

Long Term Memory Intact---------------Impaired a Little---------------Impaired a Lot

Short Term Memory Intact---------------Impaired a Little---------------Impaired a Lot

Forgetful	Y	N	Problems with Attention	Y	N
Problems Concentrating	Y	N	Problems with Organization	Y	N
Easily Confused	Y	N	Easily distracted	Y	N
Problems with Word Substitution	Y	N	Problems with Info Processing	Y	N

Driving Skills (circle) Good---------------Impaired (don't go far) ---------------Poor (and quit driving)

Give details of the above symptoms: ____

Family member observations- How is the injured person different after the injury, please describe:____________________

Physical Changes – any problems in following systems?

Sense of Taste	Y	N		Sense of Smell	Y	N
Vision	Y	N		Hearing	Y	N
Ringing in Ears	Y	N	Left Right	Testing Done	Y	N

Where ____

Balance Problems	Y	N	Testing Done	Y	N

Where____________________ Type ____________________

Neck pain	Y	N	Backache	Y	N

Any tests, evaluations, and treatments done for pain problems ____________________

Headache Y N Describe (throbbing, pulsating, pressure, piercing) ____________________

What relieves headache ____

Seizures Y N Describe ____

Give details of symptoms above: ____

Concussion/head injury intake- 2015

Medical History

Diabetes Y N Asthma Y N Hypertension Y N

Neurological Y N Heart Disease Y N Other: ______

Surgeries Y N Please describe: ______

Hospitalizations Y N Please describe: ______

Any other active medical problems: ______

______

______

Current Medications (bring the bottles with you)

	Name	Dose	How Long	For What	Who Prescribed
1.					
2.					
3.					
4.					
5.					

Over the counter and Herbal/Natural products ______

______

Do you take any medications that belong to a friend/family member? Y N If so, what? ______

Past Psychiatric History (Out Patient Treatments) ______

______

______

Medications tried in the past: ______

______

Physician(s) seen: ______

______

Inpatient Treatments (where and for what reason): ______

______

Any history of suicide attempt: ______

Family History: -

Emotional problems Y N Mom___ Dad___ Brothers___ Sisters___ Uncles/ Aunts__ Cousins___

Describe: ______

______

Alcohol/Drug Abuse Y N Who ______

Concussion/head injury intake- 2015

Social History

Coffee/Energy drinks Y ____ N ________cups per day

Smoke Y N _______cigarettes per day for __________________years

Do you want to quit Y N

Drink alcohol Y N _______drinks per day/week for________________years

Impact social/family life Y N

Drugs Y N Type________ How Often? _______ How Long? ______

IV drug use Y ____ N

Huffing or snorting any drugs Y ____ N Do you want treatment Y N

Give details of the above: ____

____

Do your family/friends complain about your alcohol/drug use Y N

Are family members and friends supportive? Y N

Hobbies ______________________ Last enjoyed ______________________

Any past or current legal problems (e.g. DUIs etc.)-______________________

History of past abuse/assaults/domestic violence?______________________

Education History

Schooling < HS____ HS ___ GED___ College___ Tech.___ Vocational___

Describe Schooling: ____

Average Grades________________

Currently in college Y N Name of College and Major(s) ______________________

Learning Disability Y N Type: ______________________

Repeated any grade Y N

Discipline problems Y N

Ever been on Disability or Workers' Comp - Y N

Describe:____

____

Current disability status

None Short term Long term Work. Comp SSDI

Last day worked: ______________________ Current Litigation Status:______________________

Involved in any community and social activities? (Church/Temple/Clubs/Sports/AA/NA/Volunteer work)______________________

____

Military service

Service ______________________ How long ______________________

Any combat exposure Y N Give details ______________________

Any service related medical conditions ______________________

Discharge: Y ______ N Honorable/Dishonorable (Circle One)

Any other relevant information not asked above ______________________

____

____

I certify that I have reviewed the above information provided by me, and to the best of my knowledge it is true and complete. I am aware that this information may be released to other parties such as insurance co., attorneys and other medical professionals/ hospitals as per my consent/authorizations, or via court orders as allowed by prevailing federal, state and/or local laws. This information may be shared with treating professionals/law enforcement authorities without your consent in case of an emergency, when relied upon in good faith. I will hold Dr. Kant and/or his designees harmless for any loss, injuries, damage that may arise from the actions taken.

I/We will be responsible for payment of charges billed if payments are denied by the insurance company(ies) for any reason. It is my responsibility to update my insurance information for billing whenever there are any changes.

Signature ____ Name _________________________________ Date ___________

Office use only:

This information was reviewed with patient and/or guardian by

1.____ Signature ______________________________________ Date ___________

2.____ Signature ______________________________________ Date ___________

Patient Health Questionnaire (PHQ-9)

Over the last two (2) weeks, how often have you been bothered by any of the following problems?

Name ____ Date___________________

		Not at all **0**	**Several days** **1**	**More than half the days** **2**	**Nearly every day** **3**
1	Little interest of pleasure in doing things				
2	Feeling down, depressed or hopeless				
3	Trouble falling asleep, staying asleep or sleeping too much				
4	Feeling tired or having little energy				
5	Poor appetite or overeating				
6	Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
7	Trouble concentrating on things such as reading the newspaper or watching TV				
8	Moving or speaking so slowly that others could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
9	Thinking that you will be better off dead or that you want to hurt yourself in some way				

If you have checked off any problems, how difficult have these problems made it for your to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Today's Score _______ Past scores_____________________________________

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The Rivermead Post-Concussion Symptoms Questionnaire

NAME:________________________________ DATE ___________________

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

1 = Not experienced at all
2 = No more of a problem
3 = A mild problem
4 = A moderate problem
5 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity,	0	1	2	3	4
Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. ______________________________	0	1	2	3	4
2. ______________________________	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

BAI

Concussion/head injury intake- 2015

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the **PAST WEEK INCLUDING TODAY**, by placing an X in the corresponding space next to each symptom.

NAME_______________________________ DATE____________________________

	Not at All-0	Mildly-1	Moderately-2	Severely-3
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

Total Score:________