# FAITH BEHAVIORAL HEALTH, PLLC

**Sadaf Noor, M. D.**
1400 Coit Rd, Bldg 22, Ste 2204
McKinney, TX 75071
Tel: 469-397-4234 Fax: 469-319-8363
fbhappointments@gmail.com

## PATIENT INFORMATION

| First Name | Middle Name | Last Name | Sex ☐ Male ☐ Female |
|---|---|---|---|
| | | | |

| Street Address | Birthdate | Age |
|---|---|---|
| | ☐/☐/☐ | |

| City | State | Zip Code | Home Phone |
|---|---|---|---|
| | | | |

| Cell Phone | Email address | Okay to leave voice mail |
|---|---|---|
| | | ☐ Yes ☐ No |

## IN CASE OF EMERGENCY

| Emergency Contact: | Relationship to Patient: |
|---|---|
| | |

| Emergency Contact Number: | Do we have permission to contact them regarding your appointments, billing or in case of emergency? ☐ Yes ☐ No |
|---|---|
| | |

**THE FOLLOWING INFORMATION MUST BE COMPLETED**

| PATIENT | INSURER / RESPONSIBLE PARTY |
|---|---|
| Name: | Name: |
| Address | Employer: |
| Phone: | Address if different than patient: |
| Identification # | |
| Group# | Relationship to patient: |

Who referred you to Faith Behavioral Health PLLC?

Current Medications/Dosage/Physician

Briefly state your reason for this visit

**NOTE: Payment is expected at the time services are rendered. Failure to provide us the information requested may result in a reduction or denial of payment by your insurance.**

# RECIPROCAL CONSENT TO EXCHANGE INFORMATION AND RECORDS

Client's Name: _____ Date of Birth: ____/____/____

I, _____, hereby consent to the release of privileged information and records and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation and authorize:

**Sadaf Noor, M. D.**
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Tel: 469-397-4234 Fax: 469-319-8363

_____
Name

_____
Address

_____ _____
Phone Fax

To exchange reciprocal information and records for the purpose of clarifying and enhancing my care and treatment including but not limited to:

_____ Psychiatric Evaluations
_____ Psychological and / or Academic Testing
_____ Diagnosis, treatment Plan and Progress Notes
_____ Parent Consultations (if the client is a minor)
_____ Other: _____

Sadaf Noor, M. D. is hereby released from any and all liability arising out of, or in any way incidental to, producing records or providing information pursuant to this authorization. (A duplicate, photo static copy or facsimile reproduction of this authorization may be used in lieu of the original.) This authorization is subject to revocation in writing only by the undersigned.

Parent/Legal guardian signature: _____ Print Name: _____

Relationship to Client: _____ Date: _____

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**Please read and initial the following statements concerning our office policies:**

_____ I certify that the information I have given on this form is true and correct to the best of my knowledge.

_____ Patients are requested to arrive at least 15 minutes prior to their scheduled appointment (virtual/in-person) time.

_____ I understand that if I arrive more than 10 minutes late for an appointment, it is not guaranteed that I will be seen. A $75.00 no show fee will be charged for this appointment if the schedule does not allow for you to be seen.

_____ Vital signs will be taken at the beginning of each medication management visit.

_____ Blood work may need to be monitored occasionally, depending on the medication regimen. Orders will be sent to either LabCorp or Quest within 24 hours of the visit.

_____ I understand that payment is required at the time services are rendered and I assume responsibility for this. I understand there is a $30.00 fee for all returned checks.
(*Note to divorced parents: Payment is the responsibility of the parent that brings the child into the office for treatment regardless of the divorce decree. The divorce decree is a matter between the divorced parents and the court, and we cannot be placed in the middle)*

_____ I understand that insurance will only be filed with insurance companies that Faith Behavioral Health PLLC and Dr. Noor is contracted with. In order to achieve this, please have all current insurance information on file. I understand that secondary insurance will not be filed.

_____ I understand that if there are any changes in my insurance coverage, I will notify the business office at least five (5) days prior to my next appointment or the visit will be self-pay or rescheduled.

_____ I understand that all information obtained in regard to my insurance coverage is not a guarantee of payment by my insurance company. The amount collected at the time of service is only an estimate. I understand that I am ultimately responsible for any and all balances on my account.

_____ I understand it is my responsibility to keep my appointments. If I am unable to keep my appointments, I will notify the office at least 24 hours in advance. I understand that I will be charged $75.00 for the time reserved if I do not call and cancel or reschedule at least 24 hours prior to my scheduled appointment.

_____ I understand it is my responsibility to keep track of my medication supply. I understand that I should request refills during regular office hours and that request received outside regular business hours will not be called into the pharmacy until the next business day.

_____ I understand that my records are protected by special laws governing psychiatric/substance abuse records and that I must sign a "Release of Information" form before any records can be released.

_____ I understand that Doctors / Therapist do not write "support animal" letters.

_____ I understand if some else other than parents/legal guardian accompany my child to the office visit then they will provide authorization letter to the front desk at the time of office visit.

_____ I understand that Doctors / Therapists do not appear in court to defend patients / clients, if for any reason there is a subpoena the client will be responsible to pay $1,500.00 for half a day or $3,000.00 for a full day in court. Payment will need to be collected in advance.

_____ I understand that Doctors / Therapist do not do any mental evaluations for court cases.

_____ I understand that FBH has the right to terminate any patients who are non-compliant to office polices / medications. This includes multiple no shows without advance notice (work meetings are not an excused absence), showing up late to appointments on a regular basis, and losing or throwing away medications.

Your calls are welcome, and we will return them promptly during business hours. We do not have an after-hours answering service so you must call the office and leave a voice mail. If you need to make an appointment, please call during business hours. If you have an emergency, please call 911 or go to the nearest Emergency Room.

I hereby authorize Dr. Noor, M. D. to provide psychiatric services to: ☐ my child

_____ _____

Parent / Legal Guardian Signature (If patient is a minor) Date

**THIS AREA LEFT BLANK INTENTIONALLY**

# FAITH BEHAVIORAL HEALTH, PLLC

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## AUTHORIZATION FOR THE RELEASE OF INFORMATION

**(INSURANCE CARRIER)**

I do hereby consent and authorize Faith Behavioral Health PLLC to release all information contained in my financial and medical records, including diagnoses and test results, to my insurance company or health plan, their agents and independent contractors, or any other person or entity that is responsible for paying or processing for payment any portion of my bill, for the purposes of administration, billing and quality and risk management. This consent applies to all records created in the course of and relating to my treatment and for the purpose of reimbursement for treatment.

I understand that I may revoke this consent at any time by giving written notice to the Faith Behavioral Health, PLLC except to the extent that action has been taken in reliance thereon. If no prior notice of revocation is received, this consent will expire six (6) months after the date of patient discharge from treatment, unless another date or condition is specified.

I understand that I have the right to inspect and copy the information to be disclosed.

I understand that if I refuse to consent to this Release of Information, the consequences will be that the insurance claim will not be filed.

Parent/Legal Guardian Signature _____ Date _____

*Notice to Receiving Agency/Person*

*This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug use patient.*

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## ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my or my child's insurance company to pay directly to Faith Behavioral Health, PLLC / Sadaf Noor, M.D. any insurance benefits otherwise payable to me or my child, if any by reason of the services described in the itemized statement rendered, and subject to the terms and limitations found in my insurance policy with the aforementioned company. THIS IS A DIRECT ASSIGNMENT OF RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assigned, and I have agreed to pay in a current manner any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

| | |
|---|---|
| Signature of Insured or Insured Representative | Date |
| Parent/Legal guardian Signature | Date |

**THIS AREA LEFT BLANK INTENTIONALLY**

# FAITH BEHAVIORAL HEALTH, PLLC

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# ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES

## Patient Copy

**YOUR RIGHTS**

- To be treated with dignity and addressed in a respectful manner.
- Consistent, quality care by qualified and trained professionals in a clean and safe setting.
- Humane care and treatment free of abuse, neglect, humiliation, threats or exploitation.
- Privacy of your treatment and your records.
- To be informed of risk, benefits and alternatives to medications and/or therapy.
- To consult with another licensed practitioner at your own expense.
- To make a complaint or grievance.
- The same legal rights and responsibilities as all citizens, unless otherwise indicated by law.
- The right to be free from discrimination due to race, color, religion, national origin, gender, disability, sexual orientation or marital status.

**YOUR RESPONSIBILITIES:**

- Please notify your provider immediately of any concerns, questions or feedback you may have regarding your sessions and your care
- Keep appointments and when unable to do so for any reason, **notify your counselor or physician's office with at least 24 hours' notice prior to your appointment. You will be charged $75.00 for appointment cancellations without 24-hour notice.**
- To pay a fee of $15.00 for any medications if required on the same day.
- To pay a fee of $30.00 for treatment reports you request on your behalf and/or for copies of your records.
- All co-pays, fees or charges will be collected at the time of service. There is a $30.00 fee for all returned checks.
- To maintain a clean and safe office environment – avoid bringing any food or drinks into the clinic.
- To maintain safe settings by not bringing weapons, non-prescribed drugs or alcohol on the premises of the clinic.
- Treat your provider, office staff and furnishings with respect and follow all posted office rules.
- Maintain supervision and responsibility for your children and family while in the office.
- Pay for any damages caused by the careless, reckless or intentional behavior of you or your family members.
- Provide accurate and complete information about current problems, past illnesses and treatments and other pertinent information.
- Inform us if you are receiving counseling, medications or other therapeutic services from another clinician.
- Participate in treatment decisions and follow the agreed upon plan or recommendations.
- Check with your counselor or physician's office about your appointment if inclement weather is forecasted.
- You may be referred to another provider for failing to follow these responsibilities.

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**Page 2**

I acknowledge that I have reviewed and was given the opportunity to receive a copy of these **RIGHTS AND RESPONSIBILITIES.**

| | |
|---|---|
| Printed Name of Patient | Date |
| Parent/ Legal Guardian Signature | Date |

**NOTICE CONCERNING COMPLAINTS**

**Complaints May Be Reported To:**

**Texas State Board of Medical Examiners**
**ATTN: Investigations**
**1812 Centre Creek Drive Suite 300**
**P. O. Box 149134**
**Austin, Texas 78714-9134**

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## PATIENT NARCOTIC & ADHD MEDICATION

_____
Patient's Printed Name

1. I understand that the medication I am prescribed for ADHD is a Class II Narcotic and the medication I am prescribed for sleep, anxiety is a Class IV narcotic.
2. I understand that the medication cannot be refilled before thirty (30) days.
3. I understand that if I lose my prescription, I will have to wait until the last due date from the original due date the last prescription was written for a refill.
4. I understand the medication is for my use only and cannot be shared with anyone else.
5. I understand that I am subject to random drug testing.
6. I understand that I will only take the medication as prescribed.
7. I understand that I cannot take illegal street drugs with this medication and if illegal drugs are found in my system with drug testing this medication will not be renewed by my provider.

_____ _____
Parent/ Legal Guardian Signature Date:

# FAITH BEHAVIORAL HEALTH, PLLC

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1400 Coit Rd, Bldg 22, Ste 2204. McKinney, TX 75071
**Tel. 469-717-0662 Fax. (866)-585-0224**

## TREATMENT SERVICES AND ASSOCIATED FEES

**Issues and Diagnoses:**

- Mood, i.e. depression, Bipolar Disorder
- Anxiety
- ADHD
- Trauma and stress-related issues
- Interpersonal relationships
- Self-esteem
- Personality disorders
- Disruptive behaviors
- Life transitions, i.e. middle school to high school/college.

**Insurance Accepted by Dr. Noor:**

- Cigna
- Blue Cross Blue Shield
- United Health Care
- Optum

**New Patient (for cash pay):**

- 60-90 min Initial Psychiatric Evaluation and Treatment Recommendation fee $250.00
- A 90-minute Psychiatric Evaluation is a full clinical assessment, which includes a clinical interview with the patient, interview with parents (for child and adolescent patients), diagnostic/severity rating scales. The evaluation will conclude with a collaborative discussion of clinical impressions and treatment recommendations.

**Follow-Up (for cash pay):**

- 30-45 min Medication Management Follow Up fee $150.00

BRING WITH YOU TO THE FIRST APPOINTMENT

1) All medications you are currently taking2)Any medical records that might be useful in your evaluation-labs, recent physical, IQ or psychological testing results, in addition for children also recent report card, behavior sheets.3) For minors, if parents are divorced or child is in another's custody the legal guardian must bring custody papers otherwise the child will not be evaluated.

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## PARENTAL CONSENT FORM FOR PSYCHIATRIC TREATMENT OF A MINOR CHILD

_____

Name of the Child (Please Print)

_____ _____

Name of Father Name of Mother

_____ _____

Signature of Father Signature of Mother

_____

If Parents Are Divorced: Name of Custodial Parent or Legal Custodial Guardian – Attach Copy of Final Divorce Decree With Court Clerk's/Judge's Signature and Seal

STATEMENT OF THE NATURE OF THE MEDICAL, PSYCHOLOGICAL OR PSYCHIATRIC TREATEMENT TO BE GIVEN

_____

_____

_____

_____

Date Treatment to Begin:

**DECLARATION THAT I/WE AM/ARE LEGALLY AUTHORIZED TO HAVE THE MINOR CHILD LISTED ABOVE EVALUATED AND OR TREATED BY DR. SADAF NOOR. IF DIVORCED I WILL PROVIDE, PRIOR TO ANY EVALUATION OR TREATMENT, A COPY OF MY/OUR FINAL DIVORCE DECREE SIGNED BY ALL PARTIES INCLUDING THE COURT CLERK, JUDGE SHOWING PROOF THE DECREE HAS BEEN ENTERED INTO AND FILED WITH THE COUNTY COURT OF RECORDS. THIS DECREE NAMES ME AT THE CUSTODIAL PARENT GIVING ME FULL PRENTAL RIGHTS OF MEDICAL TREATMENT FOR THIS CHILD.**

_____ _____

Custodial Parent/ Legal Guardian Printed Name Custodial Parent/Legal Guardian Signature and Date

# FAITH BEHAVIORAL HEALTH, PLLC

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**Screen for Child Anxiety Related Disorders (SCARED)**
**CHILD Version—Pages 2 and 3 of 3 (to be filled out by the CHILD)**

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Culty, M.Ed., David Brent, M.D. and Sandra McKenzie, PhD, Western Psychiatric Institute and Clinic, University of Pittsburg (October 1995). Email: birmaherb@upmd.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study, Journal of the American Academy of Child and Adolescent Psychiatry, 38(10), 1230-6.

Name: _____

Date_____

**Directions:**
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last three (3) months.

**QUESTIONS BEGIN ON NEXT PAGE:**

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# FAITH BEHAVIORAL HEALTH, PLLC

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| | 0<br><br>Not True or Hardly Ever True | 1<br><br>Somewhat True or Sometimes True | 2<br><br>Very True or Often True | |
|---|---|---|---|---|
| 1. When I feel frightened it is hard to breathe | O | O | O | PN |
| 2. I get headaches when I am at school | O | O | O | SH |
| 3. I do not like to be with people I do not know well | O | O | O | SC |
| 4. I get scared if I sleep away from home | O | O | O | SP |
| 5. I worry about other people liking me | O | O | O | GD |
| 6. When I get frightened, I feel like passing out | O | O | O | PN |
| 7. I am nervous | O | O | O | GD |
| 8. I follow my mother or father wherever they go | O | O | O | SP |
| 9. People tell me that I look nervous | O | O | O | PN |
| 10. I feel nervous with people I do not know well | O | O | O | SC |
| 11. I get stomach aches at school | O | O | O | SH |
| 12. When I get frightened, I feel like I am going crazy | O | O | O | PN |
| 13. I worry about sleeping alone | O | O | O | SP |
| 14. I worry about being as good as other kids | O | O | O | GD |
| 15. When I get frightened, I feel like things are not real | O | O | O | PN |
| 16. I have nightmares about something bad happening to my parents | O | O | O | SP |
| 17. I worry about going to school | O | O | O | SH |
| 18. When I get frightened, my heart beats fast | O | O | O | PN |
| 19. I get shaky | O | O | O | PN |

| | | | | |
|---|---|---|---|---|
| 20. I have nightmares about something bad happening to me | O | O | O | SP |

| | 0<br>Not True or Hardly Ever True | 1<br>Somewhat True or Sometimes True | 2<br>Very True or Often True | |
|---|---|---|---|---|
| 21. I worry about things working out for me | O | O | O | GD |
| 22. When I get frightened, I sweat a lot | O | O | O | PN |
| 23. I am a worrier | O | O | O | GD |
| 24. I get really frightened for no reason at all | O | O | O | PN |
| 25. I am afraid to be alone in the house | O | O | O | SP |
| 26. It is hard for me to talk with people I do not know well | O | O | O | SC |
| 27. When I get frightened, I feel like I am choking | O | O | O | PN |
| 28. People tell me I worry too much | O | O | O | GD |
| 29. I do not like to be away from my family | O | O | O | SP |
| 30. I am afraid of having anxiety (or panic) attacks | O | O | O | PN |
| 31. I worry that something bad might happen to my parents | O | O | O | SP |
| 32. I feel shy with people I do not know well | O | O | O | SC |
| 33. I worry about what is going to happen in the future | O | O | O | GD |
| 34. When I get frightened, I feel like throwing up | O | O | O | PN |
| 35. I worry about how well I do things | O | O | O | GD |
| 36. I am scared to go to school | O | O | O | SH |
| 37. I worry about things that have already happened | O | O | O | GD |
| 38. When I get frightened, I feel dizzy | O | O | O | PN |
| 39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport) | O | O | O | SC |
| 40. I feel nervous when I am going to parties, dances or any place where there will be people that I don't know well | O | O | O | SC |
| 41. I am shy | O | O | O | SC |

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## QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY – ADOLESCENT 17 ITEMS – SELF REPORT (QIDS-A17-SR)

**Please circle the one description for each question that best describes you for the past seven days.**

1. Falling Asleep

- ◯ 0 I always fall asleep in less than 30 minutes
- ◯ 1 I take at least 30 minutes to fall asleep, less than half the time
- ◯ 2 I take at least 30 minutes to tall asleep, more than half the time
- ◯ 3 I take more than 60 minutes to fall asleep, more than half the time

2. Sleep During the Night:

- ◯ 0. I do not wake up at night
- ◯ 1. I toss and turn a lot on some nights
- ◯ 2. I wake up at least once in the middle of the night, but I go back to sleep easily
- ◯ 3. I wake up many times in the middle of the night and usually stay awake for 20 minutes or more on most nights

3. Waking Up Too Early:

- ◯ 0. Most of the time, I wake up no more than 30 minutes before I need to get up
- ◯ 1. More than half the time, I wake up more than 30 minutes before I need to get up
- ◯ 2. I almost always wake up at least one hour or so before I need or want to, but I go back to sleep eventually
- ◯ 3. I wake up at least one hour before I need or want to, and cannot go back to sleep

4. Sleeping Too Much:

◯ 0. I sleep no longer than 7-8 hours each night, without napping during the day
◯ 1. I sleep no longer than 10 out of 24 hours a day including naps
◯ 2. I sleep no longer than 12 out of 24 hours a day including naps
◯ 3. I sleep longer than 12 out of 24 hours a day including naps

5. Feeling Sad:

◯ 0. I do not feel down, unhappy, sad or miserable
◯ 1. I feel down, unhappy, sad or miserable less than half the time
◯ 2. I feel down, unhappy, sad or miserable more than half the time
◯ 3. I feel really down, unhappy, sad or miserable pretty much all the time

6. Feeling Irritable:

◯ 0. I do not feel crabby, grouchy or cranky
◯ 1. I feel crabby, grouchy or cranky less than half the time
◯ 2. I feel crabby, grouchy or cranky more than half the time
◯ 3. I feel crabby, grouchy or cranky nearly all the time

7. Decreased Appetite:

◯ 0. There is no change from my normal appetite
◯ 1. I eat less often or smaller amounts of food than normal
◯ 2. I eat much less than normal and have to make myself eat
◯ 3. I hardly ever eat during a whole day and then only after I push myself to eat or because other people make me eat

8. Increased Appetite:

◯ 0. There is no change from my normal appetite
◯ 1. I feel a need to eat more often than normal
◯ 2. I regularly eat more often and/or larger amounts of food than normal

◯ 3. I feel like I want to eat a lot more than normal during or between meals


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9. Decreased Weight (Within the Last Two Weeks)

◯ 0. My weight has not changed
◯ 1. I think I have lost a little weight
◯ 2. I think I have lost 2 pounds or more in the past 2 weeks. My clothes are a little more loose than normal
◯ 3. I think I have lost 5 pounds or more in the past 2 weeks. My clothes are a Lot more loose than normal

10. Increased Weight (Within the Last Two Weeks)

◯ 0. My weight has not changed
◯ 1. I think I have gained a little weight
◯ 2. I think I have gained 2 pounds or more in the past 2 weeks. My clothes are a little more tighter than normal
◯ 3. I think I have gained 5 pounds or more in the past 2 weeks. My clothes are a lot more tighter than normal

11. Concentration/Decision Making:

◯ 0. There is no change in my normal ability to pay attention or make up my mind
◯ 1. I have some problems paying attention or making up my mind
◯ 2. Most of the time, I have a lot of problems paying attention or making up my mind
◯ 3. My mind has wandered so much during the past week that I have not been able to read or follow a TV show or make even little decisions

12. View of Myself:

◯ 0. I feel as worthwhile or good about myself as the people around me feel about themselves
◯ 1. I am harder on myself or more down on myself than normal
◯ 2. I blame myself for everything around me that goes wrong

◯ 3. I think a lot about my faults, both big and little.

13. Thoughts of Death or Suicide:

◯ 0. I do not think of suicide or my own death
◯ 1. I feel that life is empty or wonder if it's worth living
◯ 2. I think of suicide or my own death several times a week for several minutes
◯ 3. I think of suicide or my own death several times a day, or I have made plans or tried to commit suicide

14. General Interest:

◯ 0. There is no change from normal in how interested I am in other people or activities
◯ 1. I am less interested in things that used to be fun for me, like meeting with friends, hobbies or sports.
◯ 2. I find I have interest in only one or two of my usual interest or activities
◯ 3. I have no interest in any of the things that use to be fun

15. Energy Level:

◯ 0. I have as much energy as usual for getting things done
◯ 1. I get tired more easily than normal
◯ 2. I have to push myself more than usual, or it takes much more effort than usual to start and finish my normal activities
◯ 3. I am so tired or worn out that I have just not been able to do most of my Usual activities

16. Feeling Slowed Down:

◯ 0. I think, speak and move at my normal pace
◯ 1. My thinking is slowed down or my voice sounds dull or flat
◯ 2. My thoughts or speech are slowed down so that it sometimes take me several seconds to answer when someone talks to me
◯ 3. My thoughts and speech are so slow at times that I have not been able to Answer when someone talks to me

17. Feeling Restless:

◯ 0. I do not feel squirmy, antsy or restless
◯ 1. I am a little squirmy, antsy or restless so that sometimes I cannot stay still easily

◯ 2. I am often squirmy, antsy or restless so that I often cannot stay still easily
◯ 3. I am so squirmy, antsy or restless that I cannot sit still at all