Metro NBI
Metropolitan Neuro Behavioral Institute

CONSENT TO TREAT

I hereby voluntarily apply for treatment from Mehmud Ahmed, MD and Mark McCoy, PMHNP-BC.

I hereby authorize the release of medical information necessary to process billing claims. I also authorize payment of medical benefits to Metropolitan Neuro Behavioral Institute for all services rendered.

I understand that I am financially responsible for all charges whether or not they are paid by my insurance company.

I also understand that appointments must be cancelled at least 24 hours in advance to avoid late cancellation or no-show fees.

Mehmud Ahmed, MD, Mark McCoy, PMHNP-BC, and their affiliates participate in programs for training health care personnel. Students, interns, residents, and Licensed Associate Counselors (LAC) may participate in your treatment recommendations, conduct assessments, provide counseling, or be present at various times during your sessions. You can decline student services at any time.

If you have any concerns or questions regarding medical students, medical interns, or medical residents you may contact Dr. Mehmud Ahmed at (480) 464-4431.

_____	_____
Patient Name	Date
_____	_____
Patient/Guardian Signature	Date
_____	_____
Office Witness	Date

MEHMUD AHMED, MD, FAPA
American Board of Psychiatry and Neurology
70 N. McClintock Dr. Suite #4
Chandler, AZ 85226
480.464.4431—phone
480.464.2338—fax

PERMISSION TO COMMUNICATE WITH FAMILY & FRIENDS

☐ I choose to allow the people listed below to receive information regarding my appointment dates and times and billing issues. I understand this authorization may be revoked at any time. No aspects of care nor medical records will be released to them without a HIPAA compliant release of information being signed.

☐ I choose to **not allow** anyone participate in my care and am aware that only I will be able to receive information regarding my appointment dates and times, billing issues, or any aspects of my care unless it is a life-threatening emergency.

Parents: If your child is **over 18 years of age** and you are not their legal guardian, this form MUST include you for us to be able to discuss your child's appointment dates and times and billing issues.

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I choose to allow the stepparent/s _____, _____ to bring minor to appointment, make appointments and receive information.

☐ I do not choose to allow the stepparent/s _____, _____ to bring minor to appointment, make appointments and receive information.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date

_____ _____
Office Witness Date

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METROPOLITAN NEURO BEHAVIORAL INSTITUTE, PLLC
MEHMUD AHMED, MD, FAPA
CLINICAL CONDITIONS OF EVALUATION AND TREATME

The undersigned _____ acknowledges having scheduled a voluntary Psychiatric evaluation for diagnostic and treatment purposes with Dr. Mehmud Ahmed, MD, a Board Certified Psychiatrist and Mark McCoy, PMHNP-BC.

I acknowledge that I was provided with instructions about the evaluation process, and that the evaluation may include the completion of multiple forms for the collection of clinical information, as well as an interview with Dr. Mehmud Ahmed and Mark McCoy, PMHNP-BC.

After completion of the initial evaluation, I may be provided with the available diagnostic findings, and I am in agreement that at this point a decision can be made by either party to establish, or not, a provider-patient relationship. In the event of either myself refusing to continue with services or Dr. Mehmud Ahmed/ Mark McCoy, PMHNP-BC deciding to not be my physician, I will be provided with the name of at least 3 local psychiatric physicians capable of providing me with a second opinion and further care.

I acknowledge that Dr. Mehmud Ahmed and Mark McCoy, PMHNP-BC will not provide me or my family with formal Psychotherapy services beyond supportive therapy in the context of medication management and psychiatric assessment. If Dr. Mehmud Ahmed or Mark McCoy, PMHNP-BC recommends formal Psychotherapy services it is my sole responsibility to procure and secure those services.

I acknowledge that the completion of disability, school, and other employment forms is beyond the scope of the physicians medication management practice and appointments, and not considered part of the evaluation or medication management reimbursement fee. I may be charged a fee based on the time and complexity of the form.

I understand that my medication management visits are scheduled for 15 minutes. If I arrive 8 minutes late to my appointment based on our clock, I will be considered as having missed my appointment, and will be rescheduled for next available appointment. A medication refill will be provided. I also recognize that if I don't cancel my appointment at least 24 hours in advance a fee of $50.00 will be charged to my account. I understand that occasionally, Dr. Mehmud Ahmed, Mark McCoy, and staff will run late on his schedule due to unexpected patient situations.

Please initial:

I acknowledge that Metropolitan Neuro Behavioral Institute, Dr.Mehmud Ahmed, and Mark McCoy, PMHNP-BC **DO NOT** provide Emergency Psychiatric or Continuous Crisis Management Services. I agree to call 911 or visit my closest Emergency Room or Psychiatric Urgent Care Center/Hospital in the event of a Psychiatric Emergency.

I understand that Dr. Mehmud Ahmed and Mark McCoy's schedule is filled in advance and does not allow for patients to be seen on an urgent basis unless there is a cancellation. I understand it is my responsibility to ensure my follow-up appointments are maintained and scheduled as directed by my provider.

I acknowledge as part of my treatment, my provider will require me to obtain blood work and/or a urine drug screen. This may be new blood work and/or urine drug screen testing if the provider deems it a clinical necessity. If lab work was done recently through a coordinating physician, new lab work may not be necessary. Blood work and/or urine drug screens may be required on an ongoing basis throughout my treatment and my provider will discuss this with me.

I also acknowledge that Dr. Mehmud Ahmed and Mark McCoy, PMHNP-BC do not provide Emergency Medication refills. It is my responsibility to assure that an adequate supply of medications **is always maintained.** Medication refills need to be requested at least 4-5 days before running out of the most recent medication supply. I understand that medication refills will be completed within 3 business day, and that medication prior authorizations will be completed within 7-10 business days from receipt of the request, depending on insurance company. Any questions regarding medications or treatment should be directed to Dr. Mehmud Ahmed or Mark McCoy, PMHNP-BC at 480-464-4431,

option 3 or 5 or via email at nurse@metropsych.com.

I am aware and agree that Dr. Mehmud Ahmed/Mark McCoy, PMHNP-BC will terminate my clinical services upon my verbal or written request.

I am aware and agree that Dr. Mehmud Ahmed/Mark McCoy, PMHNP-BC may terminate my clinical services under the following

- My failure to maintain compliance with at least 2 consecutive schedule appointments without prior notification
- Any abuse or misuse of prescribed medication
- Any dangerous behavior toward staff
- My unwillingness to comply with recommended treatment recommendations, if in the opinion of Dr. Mehmud Ahmed/Mark McCoy, my lack of compliance places me or other people in danger.
- The initiation of involuntary Commitment Proceedings.

AS A REMINDER:

-I understand that my medication management visits are scheduled for 15 minutes; if I arrive **8 minutes late** to my appointment based on our clock, I will be considered as having missed my appointment. I will be rescheduled for the next available appointment. A medication refill will be provided at no charge.

- I also recognize that if I do not cancel my appointments at least 24 hour notice a fee of $50.00 will be placed on my account. I understand that Dr. Mehmud Ahmed and Mark McCoy, PMHNP-BC will run late on their schedules due to unexpected patient situations.

By initialing this box, you acknowledge that you have read and understand this reminder:

- Medication refills **must be requested at least 3-5 business days prior to running out of medication supply.** This can be done by contacting your local pharmacy directly prior to running out of medications. If authorization is needed our staff will address your requests in a timely manner. If you have a question about refills, please email or call the nurse/medical assistant directly: 480-464-4431 or nurse@metropsych.com.

- If you are in need of a refill, **please always contact your pharmacy first**, even if your medication bottle says no refills remaining. As long as you have a follow-up appointment scheduled with our office, refills can and will be authorized. Your pharmacy will fax us a request.

- I acknowledge as part of my treatment, my provider will require me to obtain blood work. This may be new blood work if the provider deems it necessary or from a coordinating physician if the lab work is recent. This will be necessary on an ongoing basis throughout my treatment and my provider will discuss this with me

I understand that in the event of service being terminated (except in cases of involuntary commitment) I may be provided with a 30 day supply of medications and the name of 3 local Psychiatrists that may be available to provide me with Clinical Psychiatric Services

Patient Name:_____

Patient Signature:_____

Today's Date:_____

Witness Name & Initials:_____

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ACKNOWLEDGEMENT OF RECEIPT OF METROPOLITAN NEURO BEHAVIORAL INSTITUTE'S NOTICE OF PRIVACY PRACTICES

Patient Name_____ Date of Birth_____

I have been allowed to review and/or have received Metropolitan Neuro Behavioral Institute's Notice of Privacy Practices.

_____ Today's Date:_____

Patient's Signature or legally authorized individual

You May Refuse to Sign This Acknowledgement

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For Office Use Only

Metropolitan Neuro Behavioral Institute could not obtain a written acknowledgement of receipt of our Notice of Privacy Practice due to the fact:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited it
- ☐ An emergency situation prevented us
- ☐ Other (please specify)

Employee Signature _____ Date _____

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