TEJPAL SINGH M.D.
105 N VIRGINIA AVE, SUITE 207
FALLS CHURCH, VA 22046

Client Registration Form

Name: _____ Date: _____

SSN:_____

Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Office Phone: _____ Cell Phone: _____

Email Address: *(optional): _____

*Please provide if you would like emailed appointment reminders, please note this method of communication may have lower level of privacy.

Would you like appointment reminder via telephone: Yes ___ No___

Emergency Contact Name: _____ Phone: _____

Relation: _____

Received HIPAA Notice of Privacy Practices: _____YES _____NO

How did you find us: _____

Whom may we thank for referring you? _____

Insurance Information:
Insurance Company: _____
Contract #:_____ Group #:_____
Subscriber#:_____
Relation to Patient: _____ DOB _____ SSN:_____
Employer:_____ Occupation: _____
Business Name/Address: _____
Is patient covered by additional insurance: Yes____ No___
Subscriber Name:_____
Relation to Patient: _____ DOB:_____ SSN:
_____
Insurance Company: _____
Contract#: _____ Group:# _____Subscriber#: _____
Business Name/Address: _____

Pharmacy Name:_____
Address: _____
Phone: _____

Note: 1. Please provide 24 hour notice if you are unable to attend your scheduled appointment.

otherwise the fee per below policy will be charged **_____(Initials)**
Vital Psychiatry Associates cancellation policy is as follows:
Cancellation 24 hours or more prior to an appointment: No Charge
Cancellation less than 24 hours before appointment: $ 75 charge
Cancellation without notice (no show): Full Charge (per nature of scheduled visit)
The associated fee must be paid prior to rescheduling an appointment
In case of extreme weather conditions VPA will notify you of clinic closing and reschedule an appointment

2. Payment for the services are due at the time of the session. In certain circumstances we can arrange a billing situation. Please contact for details. **_____(Initials)**
If VPA do not accept your insurance plan you can still see me as out of network provider. I can provide you with detailed service receipt at each of your sessions. You may get partial reimbursement for my services by submitting the receipts to you insurance provider. For details please call your insurance provider in advance to beginning treatment with VPA.

3. FEES MODEL
i) Fee For Service Model:
Initial Intake Evaluation: $300
Follow up: 50 Minutes therapy session only: $175; combined medication and therapy $225

Follow up: 20-30 Minutes $150
Writing reports, letter...: $150/hour (or prorated)
Telephone Calls: No fee for brief calls. Call >10 minutes prorated to $150 hourly rate)

ii) If you have insurance, you are responsible for the copay and deductible (if applicable) at the time the services are provided. Please make sure we have your correct insurance card with up to date policy information.

iii) I agree to pay the established rate of Vital Psychiatry Associates. It is understood that my obligation will include any balance not covered by insurance. It is further understood that if my insurance does not pay within forty-five (45) days of the services/treatment, I will become responsible for payment in full. **_____(Initials)**

iv) If the insurance is no longer accepted by Vital Psychiatry Associates or the insurance does not cover the service provided by Vital Psychiatry Associates, I am responsible for full charges of the services/treatment provided to me. I understand that I will receive all outstanding bills for the services provided. It is understood that all previous outstanding balance must be cleared prior to follow up appointment**_____ (Initials).**

4. Prescription History: We will use pharmacy information to send any prescriptions needed electronically per your request. We will review your prescription history to help with your medical care. You initials acknowledge we will be accessing your prescription history if needed. **_____(Initials)**

5. I have voluntarily entered into treatment with Vital Psychiatry Associates. Further, I consent to have treatment provided by Tejpal Singh M.D (Vital Psychiatry Associates). I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating clinician. This will help facilitate a more appropriate plan for discharge and avoid possible treatment discontinuation withdrawals. **_____(Initials)**

6. If you are running out of medication between the visit, ***please contact me at least five days before you run out***. This allows me enough time to access your records and call you prescription(s). As I may be out of office when I receive your request for a refill, please provide the following information in your message to quickly get your medication filled:

Your full name and date of birth
Your phone number, pharmacy name and phone number
Full medication name (Ex: Wellbutrin SR or XL; Paxil CR)
Medication Strength (Ex: 150mg, 300mg, 10mg, 5mg)
The exact way you take your medication (Ex: one tablet in morning and 1/2 tablet in evening

Please note if you leave a message and I do not have all this information. I will not be able to call

your prescription until I reach the office, which may delay the refill for several days.

7. EMERGENCIES
As a private solo practitioner, I do not have continuous "crisis management" services other than myself. If you anticipate or have had a history of needing frequent crisis services, you may be better served by working with an agency that can provide more comprehensive coverage from variety of professionals. We can discuss it during our initial visit.

I make every effort to be available to my patients during crisis/urgent situations and encourage you to contact me whenever a crisis occurs. You may take the following steps in case of an emergency:

During the regular daytime hours Monday - Sunday 9:00AM - 5PM, first call my office number (703) 829-0593. If I do not answer, leave a brief message stating your emergency. I will make every effort to reach you as soon as possible.

If you did not reach me at the office, or if its after hours call my cell phone (Will be provided at the first visit). If I do not answer, please leave a voice message. If you still have not reached me and have not heard back from me quickly, during your emergency, please do the following:
If you are in Fairfax County call the Fairfax-Falls Church Community Services Board, Emergency services at 703-573-5679.
If you are in Arlington County call the 703-228-4256.
Go to the nearest hospital or emergency room or Call 911
Please note having strong thoughts or impulses to harm yourself or others is a medical emergency; in such situation it is totally appropriately to contact 911 or seek help at an emergency room.

8. Miscellaneous: Please note of our policy - Dr. Singh only write letter(s) and fill form(s) if you are consistently receiving our services for 6 months. In addition, Dr. Singh does not writer letter(s) or fill form(s) for emotional support animals. **_____(Initial)**

9. Risks Associated with Treatment: Please be aware that there can be risks associated with both psychiatric medications and psychotherapy. It is my goal to protect your safety and well being at all times.

1. Risk associated with Medications: All medications can have side effects, prior to starting any new medication it is my responsibility to discuss with you the most common and most serious potential side effects and to help you weigh the risks vs. benefits. I will answer any questions you may have about the medications I prescribed to you at any time. Please be aware however that I cannot practically inform you of every possible side effect of each medication. Your responsibility lies in keeping me informed of any serious side effects you experience, changes in your medical conditions and new

medications prescribed by other providers. I may also ask you to complete a written consent form for some medications.

2. Risks associated with psychotherapy: Many forms of psychotherapy carry risks of short term emotional discomfort and/or anxiety in the process of achieving long term improvement. However these ‘side effects’ of therapy should not become intolerable or hazardous to you. If you feel that they are becoming so, please let me know immediately.

10. Statement of Principles:
I devote myself to comply with the advisories and ethical principles of American Medical Association and American Psychiatric Association. If you have concerns about our work together, please let me know. If you feel that I or any other medical or mental health professional has treated you unfairly or unethically please tell me.

Your signature below indicates that you have read this agreement and agree to abide by its terms. You have the right to revoke this agreement in writing at any time.

Client Name: _____

Client Signature: _____ Date: _____