

Simret Nanda, M.D./Peace of Mind, Inc.

Board Certified Child/Adolescent and Adult Psychiatrist

2950 Camino Diablo Suite 120

Walnut Creek, CA 94597

Phone number (925) 388-6785

Fax number (925) 309-6208

drnanda@drsanda.com

Thank you for choosing Simret Nanda, M.D.

To help me get to know you and your family, please provide the information listed below to help me best help you.

Attached are the following:

1. Intake packet – Please complete and return prior to or at your first appointment.
2. Treatment Contract
3. Consent for Release and Retrieval of Medical/Mental Health information.
4. New Patient Intake Questionnaire
5. No-Show and Late-Show Policy – must be signed and returned with packet
6. Holidays/Out of office dates
7. Electronic Payment Authorization through Retriever.
8. Financial information including explanation of Electronic Payment service, fees



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TREATMENT CONTRACT 2025

PATIENT NAME: _____

DATE OF BIRTH: _____

1. I, _____ agree to guarantee and take responsibility for payment of all charges for services rendered to the above-named patient by Simret Nanda, MD. I understand and accept that my responsibility for such charges cannot be modified or assigned without the written consent of Dr. Nanda.
2. I understand that Dr. Nanda charges \$600.00 per hour broken down by 15-minute intervals, or in-office consultation, that she charges \$600.00 per hour, broken down into 15 minute intervals, for patient consultations via telephone/email extending over 15 minutes in length, and that she charges \$600.00 per hour to review records and prepare reports, broken down by 15 minute intervals. This fee is the psychiatric medication management and treatment fees. I do understand that she has a different weekly or bi-weekly psychotherapy fees.
3. Follow-up appointments are at minimum every 3 months to continue to be an active patient in Dr. Nanda's practice.
4. I understand that Dr. Nanda requires direct payment at the time of service and does not bill insurance. Dr. Nanda provides patients with an invoice/superbill that can be used for insurance reimbursement.
5. I understand that all refills and medication changes will be done in my appointments with Dr. Nanda and that refills requested outside of my appointments will be charged a \$150 fee for 15 minutes of Dr. Nanda's time. Refills should be requested at least 7 days ahead of time so that Dr. Nanda has ample time to fill the prescription.
6. I understand that I will NOT change my medications/doses without talking with Dr. Nanda first.
7. Patients on controlled medications have to be seen in-person in the office at least once per year.
8. I understand that Dr. Nanda is a mandated reporter for all forms of child abuse and adult abuse and has to report to Child Protective services and Adult Protective services.
9. I understand that Dr. Nanda's business hours are from 9am-5pm and her private practice days are Mondays, Wednesdays and Fridays. If there is an emergency and I cannot reach Dr. Nanda then I will go to the nearest emergency room. Please be

- aware of Dr. Nanda's vacation times as she will be unreachable during those times and patients will have to go to the ER if they need psychiatric treatment.
10. I understand that, other than in emergency situation, late cancellations (less than 24 hours' notice or 1 business day prior to the appointment time) or "no shows" to scheduled appointment will result in my being held responsible for the full fee.
 11. Appointments should be made well ahead of time and last-minute appointments are for emergencies only. I understand that is Dr. Nanda's has an assistant that can be reached via email- info@drsmanda.com. Simple Practice will be used for scheduling appointments and for billing and appts can be scheduled and changed online now. This scheduling system also indicates vacation days for Dr. Nanda as well. All appts can be scheduled by Dr. Nanda's assistant and online on Simple Practice, here is the Simple practice link- <https://simret-nanda.clientsecure.me>
 12. Dr. Nanda is not using email/text to discuss medications or treatment issues. All of this has to be done in our sessions. Emails are for scheduling and sending over letters/records only.
 13. In the event that the above patient's account must be turned over to an attorney for collection, I accept full responsibility for all reasonable attorney's fees and costs that may be incurred by Dr. Nanda in the collection of said account.
 14. There is a small administrative fee (\$50) that will be charged to the patient if requesting the release of their medical records to another medical facility/medical provider
 15. On behalf of the above-mentioned patient, I authorize Dr. Nanda to release information pertinent to billing and collecting outstanding balances on the patient's account.
 16. With my signature below, I provide my consent for Dr. Nanda to provide treatment to the above-named patient.

SIGNATURE OF PATIENT (IF OVER 18): _____

SIGNATURE OF PARENT (IF PATIENT IS UNDER 18): _____

SIGNATURE OF ADDITIONAL PARTY (OPTIONAL): _____

DATE: _____

Treatment Codes and Types for Dr. Nanda:

90972 Psychiatric Diagnostic Evaluation

- For children/adolescents it is \$1800 (3 hours) – 2 hours face to face time and 1 hour to speak and review records from other treatment providers – primary care doctors/therapists/previous psychiatrist/teachers etc. *Please note that your in-person appointment with Dr. Nanda will only be 2 hours in length. *
- For Adults it is \$1200 (2 hours)- 1.5 hours face to face time and ½ hour to speak and review records from other treatment providers- primary care doctor/therapist/previous therapist etc. *Please note that your in-person appointment with Dr. Nanda will only be 1.5 hours in length. *
- Court Evaluations \$3,000 (5 hours)- 2 hours face to face time, 1 hour to speak and review records from other treatment providers, 1 hour to write up letters/reports for court, 1 hour to speak with lawyer. *Please note that your in-person appointment with Dr. Nanda will only be 2 hours in length. *

99213- Medication Follow up appts (30min) – For Children and Adults - \$300- 20min face to face time and 10min for Dr. Nanda to write her note/schedule/bill.

90792a- Medication re-evaluation appt (60min) if patient has not been seen in over > 3 months- 1 hour - \$600.

No Shows/late cancellations – responsible for the full fee of the session.

99213 Medication refill (15min) - \$150 for a 15min refill in between Dr. Nanda's appt

99213 Letter writing/forms for schools/therapists/work/landlords etc.- I charge for my time 15min-30min- \$150-\$300. Court letters take more time and I charge more for write up/letters for court.

90837- Psychotherapy (individual)- (60 min) for children/adults weekly- \$300- 50min face to face time and 10min for Dr. Nanda to write her note/schedule/bill

90847- Family psychotherapy session with patient present (60min) for children/adults- \$300- 50min face to face time and 10min for Dr. Nanda to write her note/schedule/bill

90846 Family psychotherapy session without patient present (60min) for children/adults-- \$300- 50min face to face time and 10min for Dr. Nanda to write her note/schedule/bill

99367- Treatment team meeting with schools or therapist/doctors (with/without patient present)- \$300 (30min)-\$600 (60min) depends on the length/type of the meeting.

SIGNATURE OF PATIENT (IF OVER 18): _____

SIGNATURE OF PARENT (IF PATIENT IS UNDER 18): _____

SIGNATURE OF ADDITIONAL PARTY (OPTIONAL): _____

DATE: _____

Vacation dates for 2025 for Dr. Nanda:

April 17th- April 22nd- NYC Vacation dates

May 12th- May 25th - Europe trip

July 4th - Independence day

Labor Day- Sept 2nd, 2025

October 18th- 20th for possible conference for European society of pediatrics

Nov 24th -28th for week off for Thanksgiving break. Thanksgiving Day is 11/27/25

December 22nd- December 26th week off for Christmas break. Christmas day 12/25/25

Dr. Nanda will be taking another vacation throughout the year which is currently TBD.
She will inform all clients once she knows when she will be taking this vacation.

SIGNATURE OF PATIENT (IF OVER 18): _____ SIGNATURE
OF PARENT (IF PATIENT IS UNDER 18): _____ SIGNATURE OF
ADDITIONAL PARTY (OPTIONAL): _____
DATE: _____



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CONSENT FOR RELEASE & RETRIEVE OF MENTAL HEALTH INFORMATION

Patient Name: _____ Date: _____ DOB: _____

Please Note: If consultation is requested and information is to be exchanged between this provider and a third party, the name, address and phone number of the designated third party should be listed in both the **RELEASE** and **RETRIEVE** section below

I hereby consent to **Simret Nanda, M.D.** to **RELEASE** INFORMATION TO THE FOLLOWING PARTIES. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.

These Individuals are as follows:

Name Address Phone Number

I hereby consent to **Simret Nanda, M.D.** to **RETRIEVE** INFORMATION FROM THE FOLLOWING PARTIES. This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals.

These Individuals are as follows:

Name Address Phone Number

AUTHORIZATION: I certify that this authorization to release and/or retrieve has been made voluntarily. I understand the information to be released and/or retrieved may include information related to drug abuse, alcoholism or alcohol abuse. The released and/or retrieved information may also include psychiatric and HIV/AIDS conditions.

I understand that I may revoke this authorization at any time by giving written notice to **Simret Nanda, M.D.**, except to the extent that **Simret Nanda, M.D.**, has already taken action on this request. This authorization will expire 1 year from the date treatment is terminated.

Signature of Patient or Guardian	Date
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Witness	Date
---------	------

I am revoking consent and authorization to request or release information.

Signature Patient or Guardian	Date
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NEW PATIENT INTAKE QUESTIONNAIRE

Simret Nanda, M.D. does NOT offer custody/court ordered or forensic evaluations. She will not be able to testify in court or provide written or verbal recommendations related to parent fitness or custody.

If you have any testing results (educational or psychological), please provide copies at the time of submitting the completed intake packet.

Patient's Name: _____

Birth Date: _____

Today's Date: _____

Please describe the concerns you have that led to this referral. Examples: Concerning behaviors or disturbances in mood, sleep, appetite, anxiety, concerns about school/work performance, family or peer relations, substance abuse, psychosis, mania, concentration, self-harm/suicidal issues, etc.

EMERGENCY CONTACT: (besides parent/legal guardian)

Full Name: _____

Relationship to patient: _____ Phone _____

Today's date: _____



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PATIENT INFORMATION

Full Name: _____

Date of Birth: ____/____/____

Insurance Name: _____

Member ID: _____

Street Address: _____ City: _____

State: _____ Zip: _____

Home Phone (cell): _____

Email Address: _____

Patient's primary care physician (PCP): _____

Street Address: _____ City: _____

State: _____ Zip: _____

Phone: _____

Work Phone: _____

Place of Employment: _____

Employment Status: full-time part-time unemployed

Occupation: _____

FAX: _____

PARENT OR LEGAL GUARDIAN #1

Relationship to patient: _____ Gender: M F

Full Name: _____

Date of Birth: _____ / _____ / _____

Social Security Number: _____ - _____ - _____

Street Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Place of Employment: _____

Employment Status: full-time part-time unemployed

Occupation: _____

PARENT OR LEGAL GUARDIAN #2

Relationship to patient: _____ Gender: M F

Full Name: _____

Date of Birth: _____ / _____ / _____

Social Security Number: _____ - _____ - _____

Street Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Place of Employment: _____

Employment Status: full-time part-time unemployed

Occupation: _____

Did you ever experience any type of trauma (physical, emotional, sexual, medical abuse, exposure to violence)? YES NO

If YES, please explain: _____

Past Therapists, Counselors, and Psychiatrists (if any):

Name	Address	Phone Number	Dates of Service

FAMILY BACKGROUND:

Are you:

Married YES NO Date: _____

Separated YES NO Date: _____

Divorced YES NO Date: _____

Remarried YES NO Date (1st Caregiver/Mother): _____

Date (2nd Caregiver/Father): _____

Do you have any children?

Biological YES NO Date of birth: _____

Not biological YES NO Date of birth: _____

Are your Parents/Caregivers:

Married YES NO Date: _____

Separated YES NO Date: _____

Divorced YES NO Date: _____

Remarried YES NO Date (1st Caregiver/Mother): _____

Date (2nd Caregiver/Father): _____

Did the 1st caregiver/mother have any previous marriages? YES NO Date: _____

Did the 2nd caregiver/father have any previous marriages? YES NO Date: _____

Are you adopted? YES NO If yes, at what age? _____

Parents/Caregivers occupations?

1st caregiver/mother: _____

2nd caregiver/father: _____

Highest level of education of each parent/caregiver?

1st caregiver/mother: _____

2nd caregiver/father: _____

Other individuals living in the home:

Name, age: _____

Other relatives or persons living in the home:

Name, age: _____

Name, age: _____

Name, age: _____

Name, age: _____

Siblings/Half-Siblings/Step-Siblings NOT living in the home:

Name, age: _____

Name, age: _____

Name, age: _____

Name, age: _____

EDUCATION/WORKPLACE INFORMATION:

School/Workplace: _____ Phone: _____

Type of school attended: Public Private

Special _____

Grades repeated: _____ Grades skipped: _____

Expelled? YES NO How many times? _____

Highest education level achieved: _____

Do you have any known learning disabilities? YES NO

Did you have an IEP (Individual Education Plan)? YES NO

Did you receive any special education services (speech, reading, etc.?) YES NO

How has your behavior and academic/work performance been over the past month?

MEDICAL HISTORY: Have you had any of the following:

	YES	NO	Comments
Allergies			
Allergies to medications			
Asthma			
Hearing problems			
Vision problems			
Meningitis or encephalitis			
Head injury			
Concussion			
Seizures (convulsions)			
Heart problems?			
Dizzy or passed out with exercise?			
Irregular or abnormally rapid heartbeat?			
Other injuries			
Other illnesses			
Any hospitalization?			

List all medications (psychiatric, medical, over the counter and/or herbal, supplements) that you currently take, with dosages:

ALCOHOL/SUBSTANCE USE:

How much Alcohol do you drink?

Preferred beverage: _____

Drinks per day: _____

Drinks per week: _____

How many cigarettes do you smoke?

Per day: _____

Per week: _____

What other substances do you use with any regularity?

Substance	Amount per day	Amount per month
Marijuana		
Cocaine (powder? Crack?)		
Methamphetamine		
Hallucinogens (LSD, mushrooms)		
Ecstasy		
Opiates		
Prescription medications		
Other		

Family Medical History: Please check illnesses that any of your **BIOLOGICAL** relatives have experienced:

Illness	Mother	Father	Sister/Brother	Aunt/Uncle	Grandparent	Cousin
ADHD						
Allergies						
Alcohol/drug abuse						
Anxiety						
Asthma						
Bipolar disorder						
Depression						
Sudden death before age 50						
Epilepsy (seizures)						
Learning problems						
Heart problems						
High blood pressure						
High cholesterol						
Legal problems						
Mania						
Obsessive-compulsive disorder (OCD)						
Panic disorder						
Schizophrenia						
Thyroid problem						
Tics						

DEVELOPMENTAL AND MEDICAL HISTORY:

Birth History: Biological mother's age at time of birth: _____

Biological father's age at time of birth: _____

Did biological mother smoke during pregnancy? YES NO

Drink alcohol? YES NO Use Illicit drugs? YES NO

Was biological mother under a doctor's care during pregnancy? YES NO

Were there any complications during pregnancy? YES NO

As closely as you can remember:

Age of sitting alone _____ Age of rolling over _____ Age of walking _____

Large motor skills developed: FAST SLOW AVERAGE

Fine motor skills developed: FAST SLOW AVERAGE

Were you clumsier than other children? YES NO

Did you point to things? YES NO

Age of first words? _____ Age of talking in sentences? _____

Are you: Right-handed _____ Left-handed _____ Uses both hands equally _____

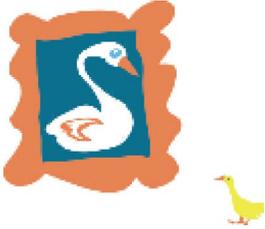
CURRENT SLEEP ROUTINES:

Complain of feeling tired or not rested? _____ /7 nights

Usual bedtimes: During school/work week? _____ Weekends/vacations? _____

Wake up time? During school/work week? _____

Weekends/Vacations? _____



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No Show and Late Policy

No Show:

If you are unable to attend a scheduled appointment, please call 925-388-6785 or email at drnanda@drsnanda.com to notify me **at least 24 hours in advance or 1 business day.**

If you fail to notify our staff of your intended absence of at least 24 hours in advance and you don't show for an appointment, you will be considered a "no show" for this appointment. If you cancel on the same day as your appointment you will be considered a "no show" for this appointment and are responsible for the full fee of the appointment time

If you are a "no show" more than 2 times, you will be considered no longer under this provider's care and will be required to make further psychiatric arrangements on your own.

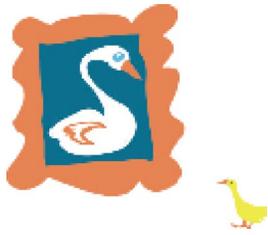
Late Show:

Patients who arrive 15 minutes or more past their scheduled appointment time will need to be rescheduled.

I, the undersigned, have read, understand and agree to follow the above conditions.

Printed Name: _____ Date: _____

Signature: _____



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Payment Policy

My practice's policy is to securely store a form of payment on file for all of your sessions. I am deeply committed to the therapeutic climate and want your therapeutic experience to be focused on you and your treatment goals.

I accept credit cards, debit cards, cash or checks. Each month you will receive an invoice by email. Statements will show that you have paid for your services in full and are ready for you to forward to your insurance company if you wish to seek reimbursement.

I don't bill insurance carriers directly; my practice model depends on spending more time with patients rather than insurance paperwork. This way we can ensure that your experience in therapy is 100% focused on your care, versus adding another party to the insurance billing process which slows things down and which distracts us from our clinical work. However I am glad to hear you have insurance and strongly advocate for patients utilizing their benefits. Each month I provide all of my patients with an insurance ready statement that they can use for reimbursement, I advise all new patients to call their insurance carrier to see what their out of network benefits may be. Many of my patients receive reimbursement for the services they have paid for.

Frequency of Visit Policy:

To remain in the care of this doctor, you must be seen at least every 3 months. If less frequent visits are considered appropriate, we will discuss whether treatment can be managed by the patient's primary care/pediatric physician

ELECTRONIC PAYMENT AUTHORIZATION Please indicate the form of payment you wish to use for any services rendered through this practice and Simple Practice Payment System. The following forms of payment are accepted: Visa, MasterCard, American Express and Discover.

Patient Information:

Patient Name: _____

Date of Birth: _____

Address: _____

City _____ **State:** _____ **Zip:** _____

Mobile Number: _____

Cardholder Information: Please indicate the name and address associated with the credit or debit card you wish to use.

Name: _____

Address: _____

City _____ **State:** _____ **Zip:** _____

Email: _____

I authorize any service fees to be deducted from the credit or debit card ending in _____ (provide the last four digits of the card).

Full Credit/Debit Card Number: _____

Cardholder Signature/Date: _____

Expiration date: _____ **Security Code:** _____

Please provide your payment information below. The debit or credit card information you provide on this form will be destroyed once your first payment has been made.

Card Type (circle one): Visa MasterCard Discover American Express

Notice of Confidentiality Acknowledgment

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read, and understand your **Confidentiality Notice** on your website <https://drsnanda.com/confidentiality/> containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature of Patient or Parent/Guardian: _____

Date: _____