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@drsnanda.com

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

Attached are the following:

1. Intake packet – Please complete, sign all portions and return prior to or at your first appointment.
2. Treatment Contract
3. Custody/Divorce Agreement (if applicable)
4. Consent for Release and Retrieval of Medical/Mental Health Information
5. New Patient Intake Questionnaire
6. No-Show and Late-Show Policy
7. Holidays/Out of office dates
8. Electronic Payment Authorization through Retriever.
9. 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@drsnanda.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. *

99213/99214- 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.
Faxing of psychiatric records to other facilities/providers requires a release of information on file and cost is $50.
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/Memorial Day

June 6th- June 22nd Conference in India

July 4th- Independence Day

Labor Day- Sept 2nd, 2025

Possibly Conference October 18-20th for European Academy of Pediatric society

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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Informed Consent: Post Divorce/Two Family Agreements

Child: _____ Is this a joint or sole custody? ___Joint ___Sole

Mother: _____ Father: _____

1: It is important for you to be informed about the services you will receive in this office. For your protection, you need to know the following.

A: **Litigation:** Psychiatrists provide diagnostic evaluations and medication management. Evaluations are often requested in terms of litigation that may arise post-divorce, for example, to help determine visitation or care patterns. The services I provide here are in the context of psychiatric care management. By signing this form, **I agree** not to request Dr. Nanda to communicate with my attorney or with any court about what he knows about me or my child. Such communication can only occur through a second mental health professional hired specifically as an evaluator to offer recommendations to me or my attorney or the court. My child must place his or her trust on the services they receive here. Protecting the psychiatric process from litigation protects my child's trust.

B. **Special Circumstances regarding confidentiality. 1)** Psychiatrists working with children need to communicate openly with both parents, the child's therapist, pediatrician, and the school. Dr. Nanda will make every effort to respect my privacy and maintain the appropriate boundaries between the two families. She will share only essential information with my child's physician and the school. By signing this form, **I agree** that information may be shared as Dr.Nanda determines to be appropriate between members of my child's two families (including me and my child's other parent) , my child's therapist and the school personnel.

2) Psychiatrists working with children need to protect the trust the child places in his or her treating doctor. While general themes may be shared with parents, there are many specifics that may remain in the privacy of the psychiatrist's office. I understand my child's need for age-appropriate privacy in his/her psychiatric treatment.

C: **Involvement of both parents:** Dr. Nanda will make every effort to make herself available for meetings with parents in a balanced fashion between households. Telephone contact is treated like a parent meeting and billed to the parent involved. I understand that reports are generally **not** available in this context.

By signing this form, I acknowledge having read and understood the above information, and agree to the above statements, conditions and limitations. I may request a copy of this form.

_____ _____

Signature of parent or guardian Today's date

_____ _____

Signature of parent or guardian Today's 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 and fax 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 and Fax 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 and Fax 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

_____ _____
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

Please be advised that Parents/Caregivers who are divorced, or are currently divorcing and share custody, you must provide a signed consent to treat from both parents, a copy of the custody agreement designating parental decision making right, or both parents to participate in the initial appointment. **Dr. Simret Nanda 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 for your child (educational or psychological), please provide copies at the time of submitting completed intake packet.

Child's Name: _____

Birth Date: _____

Today's Date: _____

Insurance Name: _____

Member ID: _____

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:_____

PATIENT INFORMATION
Full Name:_____
Date of Birth:_____/_____/_____
Street Address:_____ City:_____
State:_____ Zip: _____
Home Phone (cell): _____
Child's primary care physician (PCP, pediatrician): _____
Street Address:_____ City:_____
State:_____ Zip: _____
Phone:_____
FAX:_____

PARENT OR LEGAL GUARDIAN #1
Relationship to patient: _____ Gender: M F
Full Name:_____
Date of Birth:_____/_____/_____
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:_____/_____/_____
Street Address:_____ City:_____
State:_____ Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Place of Employment: _____
Employment Status: full-time part-time unemployed
Occupation: _____
Did your child ever experience any type of trauma (physical, emotional, sexual, medical abuse, exposure to violence)? YES NO

If YES, please explain:

_____

_____

_____

_____

_____

_____

Child's Past Therapists, Counselors, Psychiatrists (if any):

Name	Address	Phone Number	Dates of Service

Family Background

Are the Parents/Caregivers of this child:

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:_____

Is your child 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 children living in the home:
Name, age: _____

Name, age: _____

Name, age: _____

Name, age: _____

Name, age: _____

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: _____

EDUCATIONAL INFORMATION:
Name of current school:_____Phone:_____

Primary teacher's name:_____Grade:_____

Type of school: Public Private Special_____

Grades repeated:_____ Grades skipped:_____

Expelled? YES NO How many times?_____

Does your child have any known learning disabilities? YES NO

Does your child have an IEP (Individual Education Plan)? YES NO

Is your child receiving any special education services (speech, reading, etc.?)?

YES NO

How has your child's behavior and academic performance been over the past month?

Please fill in for current and all previous school years:

Grade	School Name	Academic Performance			Behavior		
		Good	**Fair**	**Poor**	**Good**	**Fair**	**Poor**
Pre-K							
KG							
1							
2							
3							
4							
5							
6							
7							
8							
9							

10							
11							
12							

MEDICAL HISTORY OF CHILD: Has your child 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 heart beat?			
Other injuries			
Other illnesses			
Any hospitalization?			

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

_____

_____

_____

FAMILY MEDICAL HISTORY: Please check illnesses that any of your child's 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						

DEVELOPMENT AND MEDICAL HISTORY

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

Biological father's age at time of birth: _____

Was this a planned pregnancy? YES NO

Was this a desired/wanted pregnancy? YES NO

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

_____

_____

_____

Was the delivery:

On time? YES NO

Early? _____ (number of weeks)

Vaginal? YES NO Forceps? YES NO Caesarean? YES NO

What were the APGAR scores? _____

Was the baby in the hospital for more than 2 days? YES NO

Did the baby require oxygen after birth? 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

Did your child seem clumsier than other children? YES NO

Did your child point to things? YES NO

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

Is your child: Right-handed_____ Left-handed _____ Uses both hands equally _____

Age when child chose one hand more than the other _____

Age when child stayed dry during day _____

Age when child stayed dry during night _____

Age when child was bowel trained _____

As an infant/toddler did your child establish the following routines normally?

Sleep/wake cycle YES NO Eating? YES NO Did your child have colic? YES NO

Was your child interested in other people? YES NO

Was your child overly sensitive to:

Sounds? (sirens, loud noises, etc) YES NO _____

Sensations? (clothing tags, socks, light touch, movements such as swinging?)

YES NO _____

Smells? YES NO _____

Tastes? YES NO _____

Was your child Slow to Warm Up? YES NO Shy? YES NO

Underactive? YES NO Overactive? YES NO Aggressive? YES NO

Current sleep routines

On average, how many nights per week does your child

Sleep in his/her own bed? _____/7 nights

Fall asleep within 20 minutes? _____/7 nights

Sleep in Parent/Caregiver's bed? _____/7 nights

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

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

Wake up time? During school 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 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

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 and families 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.

Parent or Guardian Printed Name:

_____ Date: _____

Parent or Guardian 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 card, debit card, cash or check. Each month you will receive an automated statement 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 I strongly advocate for patients utilizing their benefits. 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 the patient's primary care/pediatric physician can manage treatment.

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 and Discover. Service fees will be deducted from the designated account at the time services are rendered.

Patient Information:

Patient Name: _____

Date of Birth: _____ Address:_____

City_____ State: _____ Zip: _____

Home Number: _____

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: _____

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: _____