Phone: (832) 941-0901 Fax: (832) 941-0902

Registration Form

Name: _____
Date of Birth: _____ Social Security: _____
Marital Status: _____ Preferred Language: English Spanish
Race / Ethnicity: _____
Address: _____ Zip Code: _____
Email: _____

Home Number: _____ Cell Phone Number: _____
Work Number: _____ Driver License Number:_____

Emergency Contact
Name: _____ Phone: _____
Relationship: _____

Insurance Information

Primary Insurance
Name of Insurance_____
Name of Insured: _____
Date of Birth: _____ Relationship: _____

Secondary Insurance
Name of Insurance_____
Name of Insured: _____
Date of Birth: _____ Relationship: _____

I have read all the information and have sincerely completed the above information. I certify that this information is true and correct to the best of my knowledge. I will notify Absolute Psychiatry of any changes to the above information provided. Absolute Psychiatry will submit claims to my insurance on my behalf and I authorize payment to be issued to Absolute Psychiatry. However, for whatever reason the payment is not issued by my insurance company, I understand that I am responsible for the balance. I agree and am responsible for the balance of my account for the professional services rendered.

Signature of Patient or Guardian_____ Date: _____

Phone: (832) 941-0901 Fax: (832) 941-0902

MEDICAL OFFICE FINANCIAL POLICY

We believe that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy. This policy applies to the following clinics or facilities; Absolute Psychiatry.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, zelle, and credit/debit card payments. Payment will include any unmet deductible, co-insurance,co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause or grace period, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license due to the many cases of identity theft in the news lately. (Please do not be offended!)
2. **INSURANCE** We are participating providers with many insurance plans. We will file insurance claims on your behalf as a courtesy.

Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you may be billed.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage though we will make every effort to do so. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and will be responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.
Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours' fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self-pay patients.

3. **FORMS FEES:** completing insurance forms, copying medical records, etc. Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $350 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is requiredin advance. Fees for Medical Records is $25 for the first twenty (20) pages and $0.50 per page in excess of twenty. The office asks to allow 5-7 business days in which to copy records before making them available for patient to pick up, and these 5- 7 days will commence after payment has been received and after patient has signed this form authorizing records' release.
4. **CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess a $25 missed appointment fee for Office Visits and a $50 missed appointment fee for IV Ketamine and TOVA testing.
5. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible for charges not covered by the assignment of insurance benefits.
6. **INSURANCES WE WON'T BILL/PATIENTS WE WON'T ACCEPT INTO THE PRACTICE:** I am not currently eligible for, Medicaid/Medicare, I will notify the office in writing immediately if I become eligible for any of these payors, thus terminatingmy care from the office, who WILL NOT accept new patients with Medicaid/Medicare, nor bill these payors if patients switch after becoming established with the office.
7. **RELEASE OF INFORMATION:** I hereby authorize and direct the office to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.
8. **INSURANCE ASSIGNMENT:** I hereby authorize payment to be made directly to my provider by my insurance company for any charges for services covered by the terms of my policy. I agree to cooperate, aid and assist the facility in procuring all possible insurance benefits initiation and fulfillment of all policy provisions such insurance companies may require for payment.

Absolute Psychiatry reserves the right to not prescribe controlled substances on the first initial office visit. Absolute Psychiatry reserves the right to not prescribe controlled substances to patients who do not present some form of Texas ID.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Patient or Legally Authorized Individual Signature _____ Date _____

Print Patient's Full Name _____ Date _____

Phone: (832) 941-0901 Fax: (832) 941-0902

MEDICAL OFFICE POLICIES

PLEASE RETAIN OFFICE POLICIES FOR FUTURE REFERENCE

OFFICE HOURS: The office is open Monday through Friday 9:00 am to 5:00 pm

APPOINTMENTS: You must schedule an appointment to be seen by the doctors at the clinics of Absolute Psychiatry. Please contact the office during business hours to schedule appointments. As a courtesy we will call/text to confirm your appointment: however, it is your responsibility to maintain your schedule and be on time for appointments.
Contact us immediately if you are going to be late. If you are unable to attend your appointment, we ask that you give at least 24 hours notice so that we can attend to other patients. Without a 24 hour notice you will be charged a $25 missed appointment fee and $50 for testing and IV appointments, payment will be required prior to your next appointment. Two consecutive no shows will result in a discharge. Five no-shows/cancellations/reschedule-within-24 hours in a 12-month span, will also be subject to dismissal from the practice.

_____
Initials

CHANGES TO PERSONAL INFORMATION: You must contact the office with any changes to your personal information including phone numbers, address, name change, new or canceled insurance.

PRESCRIPTIONS & REFILLS: Due to the nature and addictive properties of OPIOIDS prescribed for psychiatry it is necessary that we evaluate your treatment plan on a regular basis. It is our policy to prescribe no more than a 30-day supply of medication. You are required to be present for your follow-up appointment. You may be required to provide a urine sample for drug screening during your appointment. Requests made by phone or through your pharmacy will not be filled. THERE ARE NO EXCEPTIONS TO THIS POLICY.

FORMS & MEDICAL RECORDS: There is a $200 charge for completion of all forms such as FMLA, Disability Request, Daycare, Gym Membership, Credit Card and Insurance Forms. Patients **must** have developed repour with provider at minimum (3) three sessions for disability forms and (6) session for FMLA forms to be completed (*subject to case by case by provider). There is a $25 charge for medical records being released to anyone other than a licensed healthcare provider. A release form must be signed by the patient or legal guardian. Payment is required and you must allow 5-7 business days for completion from the date any of our clinics receive payment.

PHONE CALLS: Keep in mind that the office receives a large volume of phone calls daily, please make calls brief and to the point by clearly identifying yourself and the reason for your call. Keep in mind that the staff cannot answer questions pertaining to your condition or treatment. Those questions need to be addressed with the provider during your appointment.

PERSONAL BEHAVIOR: Profanity, rude or discourteous behavior will not be tolerated. Inappropriate or threatening behavior will result in you being discharged from care at any of our clinics.

PAYMENT: Payment is required at the time of service unless other arrangements have been made. For insurance patients, you will need to bring your insurance card to all appointments in the event we need to re-verify your benefits.

INSURANCE: We will work with your insurance carrier to verify your benefits and get your claims paid; however, the contract is between you and your carrier. It is your responsibility to make sure that we always have current information on file and that you respond in a timely manner if your carrier requests information from you. If you have questions about your benefits you will need to contact your carrier directly. If a claim is denied because you have not provided the requested information you may be responsible for the insurance.

HMO PATIENTS: You will need to provide your PCP's contact information. You may also be asked to contact your PCP to obtain a referral.

TEST RESULTS & SCHEDULING: The office will make arrangements for diagnostic testing. Test results will be reviewed with you at your next scheduled visit. You need to call the office within 72 hours of your procedure to schedule an appointment to discuss test results.

TOVA TESTING/ KETAMINE INFUSION RESCHEDULE: If you are unable to keep your scheduled appointment, we ask that you give at least 24 hours' notice. Without 24-hour notice you may be charged a $100 facility fee for your missed appointment. Payment will be required prior to your next appointment.

HANDGUNS PROHIBITED: Pursuant to section 30.07, penal code (trespass by license holder with an openly carried handgun), a person licensed under Subchapter H, Chapter 411, government code (handgun licensing law), may not enter this property with a handgun that is carried openly. Pursuant to section 30.06, penal code (trespass by holder of license to carry a concealed handgun), a person licensed under Subchapter H, Chapter 411, government code (concealed handgun law), may not enter this property with a concealed handgun.

_____ _____
Print Patient Name Patient Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND ENCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We are committed to protecting medical information about you. We create a record of the care and services you receive for use in your care and treatment.

We are required by law to:

- Make sure that your medical information is protected;
- Give you the opportunity to review this Notice describing our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other health system personnel who are involved in your care. We may also share medical information about you with other personnel, agencies or facilities in order to provide or coordinate the different things you need, such as prescriptions, lab work and x-rays.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party.

For Health Care Operations. We may use and disclose medical information about you for the purpose of quality of care. Your medical information may also be used or disclosed to comply with law and regulation, for contractual obligations, patients' claims, grievances or lawsuits, health care contracting, legal services, business management and administration, underwriting and other insurance activities.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information to anyone involved in your medical, e.g., a friend, family member, personal representative, or may individual you identify. We may also give information to someone who helps pay for your care.

As Required By Law. We will disclose medical information about you when required to do so by federal or state law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Workers' Compensation. We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law.

Public Health Disclosures. We may disclose medical information about you for public health purposes. These purposes generally include the following:

- Preventing or controlled disease (such as cancer and tuberculosis), injury or disability;
- Notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;
- Reporting to the employer findings concerning a work-related illness or injury or workplace-related medical surveillance;
- Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and make this disclosure as authorized or required by law.

Health Oversight Activities. We may disclose medical information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Clinical Research. We may utilize medical information about you to help identify candidates that may qualify for ongoing clinical research studies.

Lawsuits and Other Legal Actions. In connection with lawsuits or other legal proceedings, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons or other lawful process.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release medical information about criminal conduct.

NOTICE OF PRIVACY PRACTICES

National Security and Intelligence Activities. As authorized or required by law, we may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Your medical information is our property. You have the following rights, however, regarding medical information we maintain about you:

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and/or received a copy of your medical information. To inspect and/or to receive a copy of your medical information, you must submit your request in writing. If you request a copy of the information, there is a fee for these services. We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed.

Right to Request an Amendment or Addendum. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum. You have the right to request an amendment or addendum for as long as the information is kept by or for us. To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us;
- Is not part of the medical information kept by or for us;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete in the record.

Right to an Accounting of Disclosures. You have the right to receive a list of the disclosures we have made of your medical information. To request this accounting of disclosures, you must submit your request in writing. Your request must state a time period that may not be longer than the six previous years. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. To request a restriction, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, only to you and your spouse. We are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

CHANGES TO PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change our privacy practices and this Notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

_____ _____

Print Patient Name Patient Signature

Teletherapy Informed Consent Form

I_____hereby consent to engage in teletherapy with the providers at Absolute Psychiatry. I understand that "teletherapy" includes clinical consultation, treatment, transfer of medical/psychiatric data, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy/coaching and consultation also involves the communication of my medical/psychiatric information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality such as HIPPA of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, these include:

    a. If you, in writing, require such disclosure;
    b. If child or elder abuse or neglect is disclosed, your counselor is required to notify the Texas Department of Family and Protective Services.
    c. If you seriously threaten or act in a way that indicates that you are very likely to harm yourself, your therapist may have to seek hospitalization for you, or call your family members or others who can help protect you. If such a situation does arise, he or she will fully discuss the situation with you before taking action, unless there is a strong reason not to for the purposes of safety.
    d. If your counselor believes that another person is at risk of serious injury or death.

3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Absolute Psychiatry that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) my provider will recommend I see him or her in office or I will be referred to a professional who can provide such services in my area.

5. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not be improve, and in some cases may even get worse. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

6. I accept that teletherapy does not provide emergency services. During our first session, my provider and I will discuss an emergency response plan. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) or text or call 988 for free 24 hour hotline support

7. I understand that I am responsible for
    a. providing the necessary computer, telecommunications equipment, and internet access for my teletherapy sessions,
    b. the information security on my computer, and
    c. arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

8. I understand that I have a right to access my medical/psychiatric information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

9. In order to participate in the teletherapy program, I agree to keep a credit card on file to be charged at time of service. By signing this consent, I agree to the charges on my credit card based on my insurance rates.

I have read, understand and agree to the information provided above.

_____ _____ _____

Client (or Guardian's) Signature Date Client's Printed Name

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Absolute Psychiatry
Address 14626 FM 2100 Rd, Ste C
City Crosby State TX Zip Code 77532
Phone (832) 941-0901 Fax (832) 941-0902

REASON FOR DISCLOSURE
(Choose only one option below)

- ☒ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☒ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

Phone: (832) 941-0901 Fax: (832) 941-0902

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed - The information covered by this authorization includes:

_____

_____

Persons Authorized to Use or Disclose Information - Information listed above will be used or disclosed by:

_____
Name of Person Organization

_____
Name of Person Organization

Expiration Date of Authorization - This authorization is effective through_____unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization - You may revoke or terminate this authorization by submitting awritten revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure - Information that is disclosed under this authorization may be disclosed again by theperson or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations. I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

_____ _____
Patient Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

Notice to Patient

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

For Staff Use Only

[ ] The Patient refused to sign
[ ] Due to an emergency situation it was not possible to obtain a signature
[ ] We weren't able to communicate with the patient
[ ] Other (Please provide specific details)

_____ _____
Employee Signature Date

Mental Health Intake Form

(all information on this form is strictly confidential)

Patient First Name:	**Patient Last Name:**
Name of Person completing form (if other than patient):	
Date Completed:	**Patient Date of Birth:**
Primary Care Physician:	**Physician Phone:**

Current Symptoms Checklist (please check all appropriate columns)

	Mild	Moderate	Severe		Mild	Moderate	Severe
Aggression	☐	☐	☐	Judgment errors	☐	☐	☐
Agitation	☐	☐	☐	Loneliness	☐	☐	☐
Anger	☐	☐	☐	Loss of interest in activities	☐	☐	☐
Anxiety	☐	☐	☐	Memory impairment	☐	☐	☐
Appetite change	☐	☐	☐	Mood swings	☐	☐	☐
Change in libido	☐	☐	☐	Obsessions	☐	☐	☐
Compulsions	☐	☐	☐	Oppositional behavior	☐	☐	☐
Crying/tearful	☐	☐	☐	Panic attacks	☐	☐	☐
Cyber addiction	☐	☐	☐	Paranoia	☐	☐	☐
Delusions	☐	☐	☐	Phobias/fears	☐	☐	☐
Depression	☐	☐	☐	Physical trauma perpetrator	☐	☐	☐
Disorientation	☐	☐	☐	Physical trauma victim	☐	☐	☐
Difficulty getting out of bed	☐	☐	☐	Poor concentration	☐	☐	☐
Difficulty making decisions	☐	☐	☐	Poor grooming	☐	☐	☐
Distractibility	☐	☐	☐	Racing thoughts	☐	☐	☐
Eating disorder	☐	☐	☐	Recurring thoughts	☐	☐	☐
Elevated mood	☐	☐	☐	Self-mutilation	☐	☐	☐
Emotional trauma perpetrator	☐	☐	☐	Sexual addiction	☐	☐	☐
Emotional trauma victim	☐	☐	☐	Sexual difficulties	☐	☐	☐
Excessive energy	☐	☐	☐	Sexual trauma perpetrator	☐	☐	☐
Fatigue	☐	☐	☐	Sexual trauma victim	☐	☐	☐
Grief	☐	☐	☐	Sleep problems	☐	☐	☐
Guilt	☐	☐	☐	Speech problems	☐	☐	☐
Gambling	☐	☐	☐	Social isolation	☐	☐	☐
Hallucinations	☐	☐	☐	Substance abuse	☐	☐	☐
Hearing voices	☐	☐	☐	Suicidal thoughts	☐	☐	☐
Heart palpitations	☐	☐	☐	Worried	☐	☐	☐
Hopelessness	☐	☐	☐	Worthlessness	☐	☐	☐
Hyperactivity	☐	☐	☐	Other:	☐	☐	☐
Impulsivity	☐	☐	☐	Other:	☐	☐	☐
Irritability	☐	☐	☐	Other:	☐	☐	☐

MEDICAL HISTORY

Current Medications

Medication Name	**Total Daily Dosage**	**Estimated Start Date**

Describe current physical health: ☐ Good ☐ Fair ☐ Poor

List any known allergies:

Past nonpsychiatric hospitalizations or surgeries:

Do you exercise regularly? ☐ Yes ☐ No

Personal and Family Medical History (Have you or a family member ever had any of the following? If family, specify which family member)

	You	Family	Who?		You	Family	Who?
Alzheimer's/Dementia	☐	☐		Head Injury	☐	☐	
Anemia	☐	☐		Heart Disease	☐	☐	
Arthritis	☐	☐		High Blood Pressure	☐	☐	
Asthma	☐	☐		High Cholesterol	☐	☐	
Behavioral problems	☐	☐		HIV Positive or AIDS	☐	☐	
Birth defects	☐	☐		Kidney Problems	☐	☐	
Cancer	☐	☐		Liver Problems/Hepatitis	☐	☐	
Chronic Fatigue	☐	☐		Lung Disease	☐	☐	
Chronic Pain	☐	☐		Mental Retardation	☐	☐	
Diabetes	☐	☐		Migraine or Cluster Headaches	☐	☐	
Ear/Nose/Throat Problems	☐	☐		Neurological Problems	☐	☐	
Eating Disorder	☐	☐		Skin Disease	☐	☐	
Emotional Problems	☐	☐		Sleep Apnea	☐	☐	
Endocrine/Hormone Problems	☐	☐		Stroke	☐	☐	
Epilepsy or Seizures	☐	☐		Thyroid Disease	☐	☐	
Eye Problems	☐	☐		Tuberculosis	☐	☐	
Fibromyalgia	☐	☐		Urological Problems	☐	☐	
Gastrointestinal Problems	☐	☐		Viral Illness/Herpes	☐	☐	
Genital/Gynecological Problems	☐	☐		Other:	☐	☐	

EMOTIONAL/PSYCHIATRIC HISTORY

Prior Outpatient Treatment? ☐ Yes ☐ No If yes, please describe:

Reason	Dates Treated	By Whom

Prior Inpatient Treatment (for psychiatric, emotional, or substance abuse disorder)? ☐ Yes ☐ No If yes, please describe:

Reason	Date Hospitalized	Where

Family History (has anyone in your family ever been treated for any of the following)?

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal
Anxiety	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal
Panic Attacks	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal
Post Traumatic Stress	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal
Bipolar Disorder/Manic Depression	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal
Schizophrenia	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal
Alcohol Problems	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal
Drug Problems	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal
ADHD	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal

Suicide Attempts	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal
Psychiatric Hospitalization	☐	☐	☐ Maternal ☐ Paternal	☐ Maternal ☐ Paternal	☐	☐	☐	☐ Maternal ☐ Paternal

Past Psychiatric Medications (if you have ever taken any of the following medications, indicate the date, dosage, and how helpful they were)

Antidepressants	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Prozac (fluoxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Zoloft (sertraline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Luvox (fluvoxamine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Paxil (paroxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Celexa (citalopram)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Effexor (venlafaxine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Cymbalta (duloxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Wellbutrin (bupropion)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Remeron (mirtazapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Serzone (nefazodone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Anafranil (clomipramine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Pamelor (nortrptyline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Tofranil (imipramine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Elavil (amitriptyline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Pristiq (desvenlafaxin)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Desyrel (trazadone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Viibryd (vilazodone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Adapin (doxepin)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Asendin (amoxapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Ludiomil (maprotiline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Norpramin (desipramine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Surmontil (trimipramine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Vivactil (protriptyline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Antipsychotics/Mood Stabilizers	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Seroquel (quetiapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Zyprexa (olanzapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Geodon (ziprasidone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Abilify (aripiprazole)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Clozaril (clozapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Haldol (haloperidol)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Prolixin (fluphenazine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Sedative/Hypnotics	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Ambien (zolpidem)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Sonata (zaleplon)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Restoril (temazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Rozerem (ramelteon)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Desyrel (trazodone)	☐			☐ Yes ☐ No	☐ Yes ☐ No

ADHD Medications	Check if taken	When?	Dosage?	Did it help?	Any side effects?
Adderall (amphetamine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Concerta (methylphenidate)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Ritalin (methylphenidate)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Strattera (atomoxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Antianxiety Medications	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Xanax (alprazolam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Ativan (lorazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Klonopin (clonazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Valium (diazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Tranxene (clorazepate)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Buspar (buspirone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Other Medications (specify)	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
	☐			☐ Yes ☐ No	☐ Yes ☐ No
	☐			☐ Yes ☐ No	☐ Yes ☐ No
	☐			☐ Yes ☐ No	☐ Yes ☐ No

SUBSTANCE USE HISTORY

Substance Use Status:

☐ No history of abuse ☐ Active abuse ☐ Early full remission ☐ Early partial remission ☐ Sustained full remission ☐ Sustained partial remission

Treatment History:

☐ Outpatient ☐ Inpatient ☐ 12-step program ☐ Stopped on own ☐ Other:

Substances Used (check all that apply)

Ever Used?	First use age	Last use age	Currently Used?	Frequency	Amount
☐ Alcohol			☐ Yes ☐ No		
☐ Amphetamines/Speed			☐ Yes ☐ No		
☐ Barbiturates			☐ Yes ☐ No		
☐ Caffeine			☐ Yes ☐ No		
☐ Cocaine			☐ Yes ☐ No		
☐ Crack Cocaine			☐ Yes ☐ No		
☐ Ecstasy			☐ Yes ☐ No		
☐ Hallucinogens (LSD			☐ Yes ☐ No		
☐ Heroin			☐ Yes ☐ No		
☐ Inhalants			☐ Yes ☐ No		
☐ Marijuana			☐ Yes ☐ No		
☐ Methadone			☐ Yes ☐ No		
☐ Methamphetamine			☐ Yes ☐ No		
☐ Painkillers			☐ Yes ☐ No		
☐ Nicotine/Tobacco			☐ Yes ☐ No		
☐ PCP			☐ Yes ☐ No		
☐ Tranquilizers			☐ Yes ☐ No		
☐ Other:			☐ Yes ☐ No		

FAMILY HISTORY

Family of Origin

Present During Childhood	Present entire childhood	Present part of childhood	Not present at all	Parents' Current Marital Status:	Childhood Family Experience:
Biological Mother	☐	☐	☐	☐ Married to each other ☐ Separated for _____ years ☐ Divorced for _____ years ☐ Mother remarried _____ times ☐ Father remarried _____ times ☐ Mother involved with someone ☐ Father involved with someone ☐ Mother deceased for _____ years Age of patient at mother's death: ___ ☐ Father deceased for _____ years Age of patient at father's death: ___	☐ Outstanding home environment ☐ Normal home environment ☐ Chaotic home environment ☐ Neglected ☐ Witnessed physical/verbal/sexual abuse towards others ☐ Experienced physical/verbal/sexual abuse from others Age of emancipation from home: _____
Biological Father	☐	☐	☐		
Adoptive Mother	☐	☐	☐		
Adoptive Father	☐	☐	☐		
Stepmother	☐	☐	☐		
Stepfather	☐	☐	☐		
Brother(s)	☐	☐	☐		
Sister(s)	☐	☐	☐		
Other:	☐	☐	☐		

DEVELOPMENTAL HISTORY

Problems during mother's pregnancy	☐ None ☐ German measles ☐ Alcohol use ☐ Other: ☐ High blood pressure ☐ Emotional stress ☐ Drug use ☐ Kidney infection ☐ Bleeding ☐ Cigarette use
Birth	☐ Normal delivery ☐ Difficult delivery ☐ Cesarean delivery ☐ Complications:
Birth Weight	_____ lbs. _____ oz.
Infancy	☐ Feeding problems ☐ Sleep problems ☐ Toilet training problems

Delayed Development Milestones (check only those milestones that did not occur at an expected age)

☐ Sitting ☐ Rolling over ☐ Standing ☐ Walking ☐ Feeding self
☐ Speaking words ☐ Speaking sentences ☐ Controlling bladder ☐ Controlling bowels ☐ Sleeping alone
☐ Dressing self ☐ Engaging peers ☐ Tolerating separation ☐ Playing cooperatively ☐ Riding tricycle
☐ Riding bicycle ☐ Other:

Childhood Health

☐ Chickenpox (age:) ☐ German measles (age:) ☐ Red measles (age:) ☐ Rheumatic fever (age:) ☐ Whooping cough (age:)
☐ Scarlet fever (age:) ☐ Lead poisoning (age:) ☐ Mumps (age:) ☐ Diphtheria (age:) ☐ Poliomyelitis (age:)
☐ Pneumonia (age:) ☐ Tuberculosis (age:) ☐ Mental retardation ☐ Autism ☐ Ear infections
☐ Asthma ☐ Allergies to:

Emotional/Behavioral Problems

☐ Drug use ☐ Alcohol abuse ☐ Chronic lying ☐ Stealing ☐ Violent temper
☐ Fire setting ☐ Hyperactive ☐ Animal cruelty ☐ Assaults others ☐ Disobedient
☐ Repeats words of others ☐ Not trustworthy ☐ Hostile/angry mood ☐ Indecisive ☐ Immature
☐ Bizarre behavior ☐ Self-injurious threats ☐ Frequently tearful ☐ Frequently daydreams ☐ Lack of attachment
☐ Distrustful ☐ Extreme worrier ☐ Self-injurious acts ☐ Impulsive ☐ Easily distracted
☐ Poor concentration ☐ Often sad ☐ Breaks things ☐ Other:

Social Interaction

☐ Normal social interaction ☐ Isolates self ☐ Alienates self ☐ Inappropriate sex play
☐ Dominates others ☐ Very shy ☐ Associates with acting out peers ☐ Other:

Intellectual/Academic Functioning

☐ Normal intelligence ☐ High intelligence ☐ Learning problems ☐ Authority conflicts ☐ Attention problems
☐ Underachieving ☐ Mild retardation ☐ Moderate retardation ☐ Severe retardation

Current or highest education level:

SOCIO-ECONOMIC HISTORY

Living Situation:
- ☐ housing adequate
- ☐ homeless
- ☐ housing overcrowded
- ☐ dependent on others for housing
- ☐ housing dangerous/deteriorating
- ☐ living companions dysfunctional

Social Support System:
- ☐ supportive network
- ☐ few friends
- ☐ substance-use-based friends
- ☐ no friends
- ☐ distance from family of origin

Financial Situation:
- ☐ no current financial problems
- ☐ large indebtedness
- ☐ poverty or below-poverty income
- ☐ impulsive spending
- ☐ relationship conflicts over finances

Employment:
- ☐ employed and satisfied
- ☐ employed but dissatisfied
- ☐ unemployed
- ☐ coworker conflicts
- ☐ supervisor conflicts
- ☐ unstable work history
- ☐ disabled:

Legal History:
- ☐ no legal problems
- ☐ now on parole/probation
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance related
- ☐ court ordered this treatment
- ☐ jail/prison _____ time(s)
  total time served:

Military History:
- ☐ never in military
- ☐ served in military – no incident
- ☐ served in military – with incident
- ☐ currently serving in military
- ☐ honorable discharge
- ☐ other type of discharge:

Sexual History:
- ☐ straight/heterosexual orientation
- ☐ lesbian/gay/homosexual orientation
- ☐ bisexual orientation
- ☐ transsexual
- ☐ asexual
- ☐ unsure/questioning orientation
- ☐ currently sexually active
- ☐ currently sexually satisfied
- ☐ currently sexually dissatisfied
- ☐ age first sex experience: ____
- ☐ age first pregnancy/fatherhood: ____
- ☐ history of promiscuity age ____ to ____
- ☐ history of unsafe sex age ____ to ____

Cultural/Spiritual/Recreational History

Cultural Identity (ethnicity, religion):

Describe any cultural issues that contribute to current problem(s):

Currently active in community/recreational activities? ☐ Yes ☐ No

Formerly active in community/recreational activities? ☐ Yes ☐ No

Currently engage in hobbies? ☐ Yes ☐ No

Currently participate in spiritual activities? ☐ Yes ☐ No

Relationship History and Current Family:
- ☐ married
- ☐ divorced
- ☐ single
- ☐ widowed
- ☐ in a relationship
- ☐ children living at home
- ☐ children living elsewhere

Save Form

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

Phone: (832) 941-0901 Fax: (832) 941-0902

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facilities named above the following rights, power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment tomy insurance company, attorney or insurance adjuster, for purposes of processing my claims for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy including the exclusive irrevocable right to collect payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company in accordance with Article 21:55 of the Texas Insurance Code or other applicable insurance or state statute. I, as thepatient and/or responsible party, further agree to cooperate, provide information as needed and appear as neededwherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for serviced rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21:55 of theTexas Insurance Code, providing attorney fees, 18% penalty, court costs and interest from judgment upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liabilitycarrier to dispense a separate draft to pay in full all services rendered payable directly to the physician/facilities named above.

STATUTE OF LIMITATIONS: I waive my rights to claim statute of limitations regarding claims for services renderedor to be rendered by the physician/facilities named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facilities named above the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/ouraddress upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic or facilities, he/she has the full and complete right to terminateresponsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument will serve as the original.

Print Name:_____ Date:_____

Signature of Patient:_____

Witness Signature:_____ Date:_____
(For Office Staff only)

Phone: (832) 941-0901 Fax: (832) 941-0902

Member Authorization form for Designated Representative to Appeal a Determination

Date:_____

Member Name:_____

Member #:_____

I hereby authorize **my provider** to appeal the determination concerning adjudication of claims billed out for services provided to me on my behalf, as my Designated Representative, and, as part of the claim appeal process.

I hereby allow my health insurance carrier, in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for the entire period of 1 year form the last date of service.

_____

Signature of Member or Legal Guardian

Phone: (832) 941-0901 Fax: (832) 941-0902

OUT – OF –NETWORK ADVANCED PATIENT NOTICE

We welcome you to our medical practice and facilities. Absolute Psychiatry has some services that are out of network for your insurance.

Your health insurance provides you with out of network benefits which allows you to receive full medical care by a non-participating physician or facility. If you would like to locate a participating provider, please contact your health insurance company.

TO BE COMPLETED BY PATIENT OR PATIENTS' LEGAL GUARDIAN.

By placing my signature on this form, I acknowledge the following:

1. I was made aware that any medical services provided such as TOVA testing , or Ketamine IV therapy are covered by my Out of network Benefits provided by myhealth insurance and will be billed out as Out of Network Claims.

2. I understand that I may be responsible for costs for services provided as specified in my out of network benefit plan and that absent financial hardship, the provider is prohibited from waiving deductibles, co-pays and co-insurances.

3. I was given an opportunity to contact my health insurance plan before obtaining services.

4. I am voluntarily choosing to obtain services and procedures from Absolute Psychiatry and affiliated Out of Network facilities.

Patient Name:_____ Date: _____

Patient/ Legal Guardian Signature:_____

Limits of Confidentiality

Services are confidential, with the below stated exceptions.

Duty to Warn: Mental health professionals are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person. We are required to inform the intended victim and notify legal authorities.

Suicide/Self harm: Depression is common emotion expressed in therapy, but if a client is feeling hopeless enough to imply or disclose a plan for suicide; steps need to be taken to ensure safety.

This would include notifying the legal authorities as well as make reasonable attempts to notify the family.

Animal abuse: I will report animal abuse, including cases of neglect and hoarding.

Vulnerable Adults and Children: Mental health professionals are required by law to report stated or suspected abuse of a child or vulnerable adult to the appropriate social service agencies and/or legal authorities.

Prenatal Exposure to Controlled Substances: in keeping with protecting vulnerable populations, Mental Health Providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

Insurance Providers: Information requested includes description of impairments, dates and times of service, diagnosis, treatment plans, treatment progress, prognosis for improvement, case notes and summaries.

I have read and understand the above-- stated limitations to confidentiality. I accept the subsequent ramifications should there be a need to act on one of the above stated exceptions. Other than the noted exceptions, if there are reasons to disclose my protected confidential information I understand that I will be provided a Release of Information form.

Client Signature:
_____Date:_____

Appointment Policy

(Effective February 13, 2023)

Due to the heavy demand for services and out of respect for our clients on our waiting list, we have updated our Appointment & Payment Policies:

- Initial Appointments: A 24-hour notice is required to reschedule an initial appointment, otherwise the potential client may rotate to the waiting list.

- Canceling or rescheduling an appointment: If you need to cancel or reschedule your appointment, we require that you give us at least 24 hours advanced notice. This is so another client in need might be able to use your appointment time. If client fails to provide a 24-hour notice two times within a 2-month time period, the client may be placed on "Same Day Only" appointments. *Same Day Only appointments can be made by calling our clinic on a day that you know you'll be able to keep an appointment. Clients are encouraged to call first thing in the morning to inquire about their provider's availability for that day only. Clients on the "Same Day Only" list will be unable to schedule appointments in advance.

- Missed Appointments: If you have 2 missed appointments within a 2-month time period, you will be transferred to our "Same Day Only" appointment list. Any appointments that may be scheduled ahead of time will be removed from the schedule.

- Arriving late for an appointment: Clients who are 15 minutes or later for an appointment 2 times within a 2-month time period may go on "Same Day Only" appointments.

Payment Policy

- Credit Card Payments: A credit/debit card is expected to be on file for clients choosing to use credit/debt for their preferred method of payment.

- Co-pays and Co-Insurance: Co-pays, deductibles and insurance co-portions are due at the time of service. If a minor child is being brought by someone besides the guardian or if an adolescent is not accompanied by the guardian, the guardian will be responsible for sending payment with the child or calling before the appointment time to process a debit or credit card payment.

If you have any questions, please see a member of our front desk staff or call our center at 832-941-0901.