Thank you for choosing **Bracken Psychiatric Services**.

In order to process your information accurately and quickly, please make sure you do the following:

1. Fill out all form questions **completely** including social security numbers and valid Texas I.D. We cannot process your information without it.
2. Responsible party must sign all applicable documents.
3. Fax, email or mail the documents to our office. Once your forms have been received it will take a minimum of 1 week to process. You will need to call our office to schedule an appointment.

We look forward to seeing you.

Jill Bracken D.O.
and Staff

Bracken Psychiatric Services
3200 Southern Dr. #107 Garland, Tx 75043 Ph: (972) 278-5385 Fax: (972) 692-8687
E-mail: admin@brackenmentalhealth.com www.brackenmentalhealth.com

AGENCY/FOSTER PATIENT

PATIENT INFORMATION

Patient Name ______________________ Birth Date ______________________

Street Address ______________________ S.S.# ______________________ (Required)

City ______________________ State ______________________ Zip ______________

Home Phone ______________ Cell ______________ Email ______________________

Patient Lives With ☐Foster Family ☐Relative ☐Shelter ☐Other__________ Sex ☐Male ☐Female

Siblings in our practice ____

GUARDIANSHIP INFORMATION

Foster Mom Name ______________________ Foster Dad Name ______________________

Street Address ______________________ # Years as a Foster Parent ______________

City ______________________ State ______________________ Zip ______________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

AGENCY INFORMATION

Name of Placement/Care Agency ____

Agency Address ______________________ Phone # ______________________

City ______________ State __________ Zip __________ Email ______________________

Case Manager's Name ______________________ Phone # ______________________

CPS Caseworker's Name ______________________ Phone # ______________________

INSURANCE INFORMATION

Insurance Co. ______________________ ID# ______________________

PLEASE INCLUDE A COPY OF THE C.P.S. PLACEMENT PAPERS.

Guardian/Responsible Party ______________________ ______________________
Signature Print Name

Description of Patient Guardian Authority ______________________ Date ______________

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I hereby authorize Bracken Psychiatric Services to treat the above named patient and to release any medical records required by the insurance company in order to process claims. Payment of all services is assigned to Bracken Psychiatric Services. I understand that I am responsible for charges not paid by my insurance carrier within sixty (60) days of services within the limits of my policy and that **payment of co-payment and/or coinsurance is required at the time of service.**

NOTE: Insurance Pre-Authorization: It is the patient's responsibility to notify this office if your insurance carrier requires pre-authorization for any services.

By signing below I certify that all information given in the supporting documentation I have provided is true and correct to the best of my knowledge.

Patient Name____

_______________________________	___________________________	__________
Responsible Party/Guardian	Signature	Date

Copy Patient's Insurance Card and
Responsible Party's valid Texas I.D. Here

Form will not be processed without it.

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ **Date of Birth:** ________________

I hereby acknowledge that I have received a copy of Bracken Mental Health's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____ _______________________________

Signature of Patient or Legal Representative **Date**

____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

- -

FOR OFFICE USE ONLY

Patient ID #: ______________________

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

____________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____
____
____
____
____

- ☐ Other (Specify)

____
____
____
____
____

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CONSENT FOR TREATMENT & ACKNOWLEDGEMENT OF REVIEW OF POLICIES & FINANCIAL OBLIGATION

I authorize and direct **Bracken Psychiatric Services** to perform the following treatment upon me or my child: Psychiatric Evaluation & Psychiatric Medication Management including Psychotherapy.

My consent is based on a clear explanation from the provider including:

1. My Diagnosis
2. The Differential Diagnosis
3. Description and purpose of the proposed treatment
4. Expected benefits and outcomes of the proposed treatment.
5. Risks associated with the proposed treatment.
6. Alternatives to the proposed treatment (including risks and benefits)
7. Consequences of no treatment.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the treatments. With my signature below I grant this consent without duress, confusion, or pressure from **Bracken Psychiatric Services**

I understand and agree that I will be financially responsible for any and all charges for services not paid by the insurance for my visits. This includes any fees or services provided by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or clinic to know if the insurance will pay for my visit and/or if a prior authorization is required.

I agree to make full payment for any and all denied claims for any reason.
I understand and agree it is my responsibility to know if the insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician I am seeing is a contracted in-network provider recognized by the insurance company or plan.
If the physician I am seeing is not recognized by the insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand and agree to be financially responsible\and make full payment.
I understand policy guidelines are available on www.brackenmentalhealth.com and at the office. I have received a notice of prescription policies. I have received notice of appointment policies and the financial obligation letter.

HIPAA Authorization

I authorize Bracken Psychiatric Services Providers and Staff to access my/the patient's claims medication history through our electronic prescription service for the purpose of regular healthcare operations. I understand this consent may be revoked in writing at anytime.

I consent to receive services by interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring, or other communications benefiting a patient if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so.

________________________ ________________________ ____________

Responsible Party/Guardian Printed Name | Signature | Date

Child Name ________________________________ Birth Date ____________

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Financial Obligation Letter

Dear Patient:

Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost-effective psychiatric care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan and our office.

Payment Guidelines:

- You must pay any copayments, coinsurance and/or deductibles at the time of service, unless other arrangements have been made **in advance** with our office.
- We accept cash, checks, money orders and credit cards (MasterCard and Visa).
- We charge a $30.00 fee for all returned checks. (We accept cash, credit card, money order or cashier's check only as payment for returned checks and fees.)
- We will file your insurance carrier as a courtesy.
- ***If you receive payment from the insurance company, please forward the payment (and all other papers you received) to our office. Please do not send the payment back to the insurance company.***

When do you present your insurance card?

Please present your insurance card at EACH VISIT. If there has been a change in your insurance we require a minimum of 48 business hours notice of the change**. If you cannot provide us the change of information within 48 business hours of your next appointment we will see you as a self pay and you will be charged the self pay rate for that visit.** If you come in to your appointment with new insurance and have not submitted the information to us 48 hours prior, we consider it as your intention of not using your benefits for that visit and your willingness to pay the self pay rate. Bringing your change of insurance information to the appointment without prior notice is considered your omission of using your benefits for that visit and expectation of paying the full self pay rate at the time of the visit. The missed appointment fee will apply if there is a cancelation with less than 24 business hours notice. Please visit www.brackenmentalhealth.com for the change of insurance form. Once we are able to get the benefits and bill the insurance and the visit is paid we will promptly refund your self payment.

What happens if the insurance company denies payment?

Sometimes your insurance company will refuse payment of a claim for some of the following reasons:

- There is a pre-existing illness or condition that your insurance policy does not cover.
- You have not met your deductible for the calendar year.
- This type of psychiatric service is not covered. The insurance was not in effect at the time of service;
- You have other insurance which must be filed first.
- You have exceeded your maximum dollar/visit amount; and/or
- You did not have a referral number for your visit/service.

If your insurance denies your claim for any of the above or other reasons, our office cannot be responsible for the bill. It is your responsibility to pay the denied amounts in full.

What happens if I have Medicaid, NorthSTAR or Amerigroup and it is not active at the time of my appointment?

You are automatically a self pay patient and all fees and charges will apply. If you are not eligible for your state insurance at the time of your visit and you do not intend to keep your appointment and pay the self pay rate you must contact the office 24 business hours prior to your appointment to cancel.

We value you as a patient and are eager to serve you. Our first priority is to provide you with the best possible care, If you would like to contact our office, you may call us at 972-278-5385.

Sincerely,
Bracken Psychiatric Services

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf. Both Bracken Psychiatric Services and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail all payments, deductions and adjustments per my plan's guidelines.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company as applicable by state and/or federal law.

Patient Name	Date of Birth	
Parent/Guardian Name	Signature	Date

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AUTHORIZATION FOR ANOTHER ADULT TO BRING THE PATIENT TO APPOINTMENTS AND RELEASE OF MEDICAL INFORMATION ONLY

Note: This form is not for records release or release of information other than what is required during the office visit.

I hereby authorize my psychiatrist and/or employees of Bracken Mental Health P.A. to discuss my treatment with the following:

NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED

- **I understand that incomplete forms will be null and void; no exceptions.**
- I understand that specific information to be disclosed may include history of *Drug or Alcohol Abuse* or *Mental Health Treatment*, information concerning communicable diseases such as *Human Immunodeficiency Virus (HIV)*, and *Immune Deficiency Syndrome (AIDS)*, laboratory test results, treatment progress, and any other such related information. **This authorization will expire 1 year from the date of my signature.**
- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I further authorize that a photocopy of this authorization is acceptable as an original.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
- The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: Privacy Officer: 3200 Southern Dr. #107 Garland, Tx 75043 **Phone:** 972-278-5385 **Fax:** 972-692-8687

Patient Name____

Patient Date of Birth________________________

Lawful Parent/Guardian/Conservator Printed Name ____

Patient/Parent/Guardian/Conservator Signature____

Date_________________________ **Relationship to Patient**____

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Patient History

Please review the following and check any *current* symptoms that pertain to you.

☐ Depressed Mood	☐ Inflated Self Esteem
☐ Sleep Problem	☐ Don't Seem to Need Sleep For Days
☐ Change in Appetite	☐ Racing Thoughts
☐ Decrease Interest	☐ Excessive Talking
☐ Decrease Energy	☐ Spending Spree
☐ Difficulty in Concentration	☐ Distractibility
☐ Guilt	☐ Impulsive Behavior
☐ Irritability	☐ Trying To Do Way Too Much
☐ Crying Spells	☐ See / Hear Things That May Not Be Real
☐ Excessive Worrying	☐ Suspect / Believe Things That May Not Be Real
☐ Often Tense / Keyed Up	☐ Can Not Stop Repetitive Thoughts
☐ Panic Attack	☐ Can Not Stop Repetitive Behavior
☐ Intrusive / Recurrent Memory of Past Time	☐ Hyper Vigilant

Past Psychiatric Treatment

Have you seen a psychiatrist in the past? ☐ No ☐ Yes

If yes, when and Psychiatrist's name: ____

Have you seen a therapist in the past? ☐ No ☐ Yes

If yes, when and Therapist's name: ____

Have you ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes

If yes, when and where were you hospitalized? ______________________________________

Have you taken any psychiatric medications in the past? ☐ No ☐ Yes

If yes, what are the names of the medications? What were the benefits of taking it? Did you experience any side effects? ____

____

____

____

Patient Name: ______________________________ Date: ____________________

Occupation: ______________________________ Educational Level: ______________

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Tobacco / Alcohol / Drug Use

Do you use tobacco? ☐ No ☐ Yes

If yes, what is the amount and how often? ____

Do you drink alcohol? ☐ No ☐ Yes

If yes, what is the amount and how often? ____

Do you use illicit and/or prescription drugs (not prescribed to you)? ☐ No ☐ Yes

If yes, what are the names of the illicit and/or prescription drugs. What are the amounts and how often are they taken? ____

Medical History

Do you have a primary care physician? ☐ No ☐ Yes

If yes, what is your primary care physician's name? ______________________________________

Do you suffer from any of the following medical problems?

☐ Hypertension	☐ Hypertension	☐ Stomach Ulcers
☐ Cong. Heart Failure	☐ Diabetes	☐ Head Injury
☐ Heart Disease	☐ Endocrine (Other)	☐ Seizure
☐ Cardiac (Other)	☐ Asthma	☐ Stroke
☐ High Cholesterol	☐ Liver Disease	☐ Neurological (Other)
☐ Other Medical Problem (Explain):		

Please explain any family medical history ____

____

____

If any, please explain family psychiatric history ____

____

____

Patient Name: ______________________________

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Have you ever been hospitalized for medical reasons or had surgery? ☐ No ☐ Yes

If yes, please explain. ____

____

____

Medication

Please list all current medications and include all over the counter and herbal medications.

Medication	Dose	Frequency

Do you have allergies to medication and/or food? ☐ No ☐ Yes

Medication / Food	Reaction

Legal

Do you have any current or past legal problems? ☐ No ☐ Yes

If yes, please explain ____

____

____

Patient Name: ______________________________

______________________________ ______________________________
Patient / Parent / Guardian Signature Date