1904 Longmire Rd
Suite 401
Conroe, TX 77304

Magnolia Psychiatry

22325 Gosling Rd.
Spring, TX 77389

13145 Spring Cypress Rd.
Building #3 Ste. B
Cypress, TX 77249

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature of Patient or Legal Guardian:_____

Patient Name:_____ Date:_____

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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Magnolia Psychiatry
www.magnoliapsychiatry.clinic
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f. 281-547-7911

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Patient Treatment Contract

I am a patient at Magnolia Psychiatry and voluntarily agree to this treatment contact as follows:

1. I agree to keep all appointments, and to be on time to them.

2. I agree to not sell, share or give any of my medications to another person. I understand that such mishandling of my medication is a serious violation to this agreement, and it would result in termination of treatment without any recourse for appeal.
3. I understand that if any illegal/disruptive activities are observed or suspected by employees of the pharmacy, they will be reported to Magnolia Psychiatry and could result in termination of treatment without any recourse for appeal.

4. I understand that my prescription refills will be provided at my regularly scheduled appointment. If I miss an appointment, I may not receive my prescription refill until the next scheduled appointment.

5. I understand that the prescribed medication is my responsibility. I agree to keep it safe and secure. I understand that if my medications are either lost or stolen, replacement prescriptions may be given with proper documentation and will be done at the sole discretion of my provider(s).

6. I agree not to obtain controlled medications from any other doctors, pharmacies or other sources without notifying my treating provider at Magnolia Psychiatry

7. I agree to take my medication as my provider has instructed and not to alter the way I take my medication without first consulting with my provider.

8. I understand that medication alone is not sufficient treatment of my condition and I agree to participate in all other treatment modalities as discussed and specified in my treatment plan.

9. I agree to abstain from all addictive and/or illegal substances.

10. I agree to provide urine samples/drug screens and have my provider test my blood alcohol, and controlled substance levels as needed.

11. I understand that any violation of this contract may be grounds for termination of treatment.

Patient's Name: _____ **DOB:** _____
Patient's Signature: _____ **Date:** _____

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Informed Consent for Telehealth-Based Healthcare Services

Patient Name _____ DOB_____

Practitioner Name_____ Date Consent Discussed_____

Introduction

Magnolia Psychiatry often use of Telehealth and related technologies to facilitate the delivery of healthcare services. Telehealth involves the use of electronic communications to enable health care providers and patients at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include psychiatrists, psychologist, nurse practitioners, therapists, primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may, but not necessarily, include any of the following: medical images, instant messaging, chat, telephone and/or email conversations, patient medical records, live two-way audio and video, and output data from medical devices and sound and video files.

Expected Benefits

- Improved access to medical care by enabling a patient to remain at a remote site while the practitioner obtains test results and consults from healthcarepractitioners at distant/other sites.
- More efficient medical evaluation, treatment and management.
- Obtaining expertise of a distant specialist.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) toallow for appropriate medical decision making by the practitioner.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of theequipment. In the event that there is an equipment or technological failure during a Telehealth encounter, you should call the following phone number for instructions from your practitioner on how to receive follow-up or ongoing care 281-724-7980.

  In very rare instances, security protocols could fail, causing a breach of privacy of personalmedical information.
- In rare cases, a lack of access to complete medical records may result in adverse druginteractions or allergic reactions or other judgment errors.
- In the event of any adverse events or unexpected reaction to treatment that may occur during or after your Telehealth encounter, you should follow-up with your primary care physician or emergency room, if applicable, or you may call your practitioner at the following phone number 281-724-7980 for any non-urgent issues. Telephone calls will be returned within 72 hours.

By signing this form, I understand the following:

1. I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care at any time, without affecting my right to future care ortreatment.

2. A variety of alternative methods of medical care may be available to me, andthat I may choose one or more of these at any time. My practitioner has explained the alternatives to my satisfaction.
3. My practitioner must clearly disclose his/her identity, including information such as the practitioner's name, address, contact information, and medical licensing credentials.
4. Magnolia Psychiatry will not allow any other people to observe or participate in the Telehealth encounter without my knowledge or advance consent.
5. Magnolia Psychiatry will not make recordings of any video or telephone encounters about me without my advance consent.
6. I may request a copy of my medical information and/or that my medical information be sent to my primary care provider or other health care provider, if applicable.
7. My practitioner must provide appropriate follow-up care or recommend follow-up care as necessary.
8. I have the right to know what personal data may be gathered about me and by whom.
9. I have been informed about when online communication should not take the place of a face-to-face interaction with a practitioner.
10. I have the right to be provided meaningful opportunities to give feedback about any concerns I may have about my care and that Magnolia must review and respond to those concerns in a timely and appropriate manner.
11. Magnolia Psychiatry must obtain my express consent before forwarding any of my identifiable information to a third party other than in accordance with HIPAA and other applicable laws.
12. I must verify my identity and location prior to initiating a Telehealth encounter. If I am outside of the state of Texas at the time of my appointment I will be charged the no-show fee because the appointment would not be able to proceed.
13. Telehealth may involve electronic communication of my personal medicalinformation to other medical practitioners who may be located in other areas, including out ofstate.
14. I agree to hold harmless my Practitioner for delays in evaluation or for information lost due to such technical failures.
15. It is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other healthcare providers.
16. I may expect the anticipated benefits from the use of Telehealth in mycare, but that no results can be guaranteed or assured.
17. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguardthe data and to ensure its integrity against intentional or unintentional corruption.

Patient Consent to The Use of Telehealth

I have read and understand the information provided above regarding Telehealth, have discussed it with my practitioner or such assistants as may be designated, and all of my questionshave been answered to my satisfaction. I hereby give my informed consent for the use of Telehealth in my medical care.
I hereby authorize Magnolia Psychiatry practitioners to useTelehealth in the course of my diagnosis and treatment.
Signature of Patient _____ Date _____
(or person authorized to sign for patient)

If authorized signer, relationship to patient_____

I have been offered a copy of this consent form _____
(patient's initials or authorized agent's initials)

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services.

HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human Services.www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I have read and understand this document:_____

[signature]

Date:_____

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CONSENT FOR OFFICE POLICIES AND PROCEDURES

Magnolia Psychiatry is dedicated to providing excellent behavioral health services and treating patients with dignity and respect. Below are our office policies and conditions of care: (*Please initial below where indicated as acknowledgement and consent of all office policies and procedures)*

Emergency Calls: For after hour emergencies, please call 911 or go to the nearest emergency room. Patients can call 2817247980 and leave a message for non-emergencies only. All messages will be addressed as soon as they are received and processed by our office staff. If you need to speak with the physician, calls will be returned based on clinical issues that need to be discussed and physician's availability.

___ **Non-Emergency Calls**: A $65 charge will apply for any non-emergency calls made by providers.

___ **Billing Policy**: Magnolia Psychiatry will bill your insurance, on your behalf; provided we are contracted with your insurance company and you are not a private pay patient. The responsible party agrees to provide all insurance information, at or prior to the first appointment. The responsible party also agrees to notify Magnolia Psychiatry of any changes in insurance coverage within 10 days and is responsible for all charges not covered or not paid by the insurance for any reason.

___ Co-payments, deductible & any fees not paid by the insurance are due at the time of service.

___ Written court reports, copying of records and legal work may be subject to an additional charge.

- A $25 charge for the first 25 pages and $0.25 per page, thereafter, will apply for all copies of medical records.
- A charge of $200 per hour will apply for ALL memos, completed disability/FMLA paperwork and will be completed at the discretion of the provider only.
- Our regular clinician hourly charge for any other work, not covered by insurance is $300 per hour.

___ **Appointment Cancellation:** If you wish to reschedule or cancel your appointment, it must be done so at least 24 hours prior to your appointment. If you fail to show up to your appointment, cancel or reschedule your appointment within the 24 hour deadline, you will be required to pay the full cost of the session which is $300 for initial consultation, $150 for follow ups or $125 for counseling.

___ **Active Patient:** You will automatically be considered inactive after two missed appointments without notice or passage of two months without an appointment, with no reply to office contact attempts.

___ **Termination of Treatment:** Treatment can be terminated if treatment is not progressing as expected or there is lack of expected clinical improvement for any reason; failure to follow the recommended treatment plan; delinquent payments; failure to keep the scheduled appointments as per office policies.

___ **Office Policies and Procedures Notice:** I acknowledge that I have reviewed a copy of the Office Policies and Procedures and the Controlled Substances Agreement (All documents are available for review at front desk.).

I hereby authorize Magnolia Psychiatry to conduct an evaluation and perform treatment for myself and/or my dependents with regards to psychiatric or behavioral problems. I have read and understand the above office policies and agree with these policies.

Patient's Name: _____ DOB: _____
Patient or Parent/Guardian Signature: _____Date: _____

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Additional Office Policies and Procedures

___ **Monetary Credits:** Patients may sometimes accrue credit on their accounts with Magnolia Psychiatry. This credit can be redeemed as a refund to a charge previously processed by Magnolia Psychiatry. It is not possible to process refunds 12 months after the original charge, so any credit will expire after 12 months.

Patient's Name:_____ DOB:_____
Patient or Parent/Guardian Signature:_____
Date:_____