Magnolia Psychiatry
17510 Huffmeister Rd. #103
Cypress, TX 77429
www.magnoliapsychiatry.clinic
p. 281-724-7980
f. 281-746-6268

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Name: _____

Suffix (Circle): Jr. Sr. III IV Date of Birth:_____ Gender: □ Male □ Female □ other

Parent/Legal Guardian Name (If Applicable): _____

Marital Status: □Single □Married □Divorced □Separated □Widowed SSN:_____

Spouse Name:_____ Spouse Number: (__) _____ - _____

Home Address:_____City:_____State:_____Zip Code: _____

Home Phone: (__) _____ - _____ Mobile Phone: ( ) _____ - _____

*Email: _____

*An email address and social security number is required to access our patient portal.

EMERGENCY CONTACT

Full Name: _____ Relationship:_____

Home Phone: ( ) _____ - _____ Mobile Phone: ( ) _____ - _____

PATIENT EMPLOYMENT/SCHOOL DETAILS

Employment Status: □ Full-Time □ Part-Time □ Not Employed □ Self-Employed □ Military

Employer Name:_____ Work: (__) _____ - _____

Address:_____City:_____ State: _____ Zip: _____

Student Status: □ Full-Time □ Part-Time □ Not a Student School Name: _____

REFERRAL AND PHARMACY INFORMATION

Referring person: _____ Phone: ( ) _____ - _____

How did you hear about us? _____

Clinician Referral: ___ Google: ___ Social Media: ___ Friend/Family: ___ Other: _____

Please let us know which pharmacy you prefer:

□ Walgreens □ CVS □ HEB □ Kroger □ Target □ Sam's Club □ Walmart □Other:_____

Address: _____

Phone Number:_____

Mail Order Pharmacy: □ CVS Caremark □ Express Scripts □ Prime Mail □ Other:

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FINANCIAL RESPONSIBILITY

Primary Insurance Name: _____ Behavioral Health Phone Number: _____

Policy Number: _____ Group Number: _____

Insurance Claims Address (Back of Card): _____

Policy Holder Name: □ Self Full Name/Relationship: _____

Policy Holder DOB: _____/_____/_____

Secondary Insurance Name: _____ Behavioral Health Phone Number: _____

Policy Number: _____ Group Number: _____

INSURANCE ASSIGNMENT AND SELF PAY AGREEMENT

I certify that I have insurance coverage with the primary insurance company and the second insurance payer, if applicable, listed above. I assign directly to Magnolia Psychiatry all insurance payments, if any otherwise payable to me for services rendered. I understand I am financially responsible for any deductible, co-insurance, copayment, non-covered charges, and any balances not covered under a signature for all insurance submissions. I understand that it is my responsibility to pay for any services rendered at the time of visit.

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

Payment for services rendered is the responsibility of the patient, parent, or guardian. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage on your behalf. *However, you are ultimately responsible for the payment of your bill, regardless of insurance coverage.* Once insurance claims have processed, any remaining balance(s) will be billed to the patient. If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the patient. If insurance issues arise, it is the responsibility of the patient to contact the insurance company, group plan, administrator, or employer representative for resolution. A patient's insurance policy is a contract between the patient and the insurance carrier. Magnolia Psychiatry and its associates are not parties to that contract and cannot act as a mediator with the carrier or employer. The patient will become responsible for complete payment to the provider if coverage has terminated due to lack of premium payment.

As required by insurance mandates, it is the responsibility of the patient to obtain any necessary authorization for medical treatments. If a referral is required for treatment, it is the responsibility of the patient to obtain the referral and present it at the time of treatment. If the patient is treated without the proper referral or authorization as required by the insurance carrier, the patient assumes responsibility for payment of all fees at the time of service.

Patient's Name: _____ DOB: _____
Patient's 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:

Patient initials

Emergency Calls: For after hour emergencies, please call 911 or go to the nearest emergency room. Patients can call 281-724-7980 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.

___ Any returned check from the bank is subject to a $30.00 processing fee.

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 completed disability/FMLA paperwork and will be completed at the discretion of the provider only.
- Our regular physician hourly charge for any other work, not covered by insurance is also $200 per hour.

Appointment Cancellation: There is a 48-hour cancellation policy for all appointments. A $150 fee will be applied to the patient's account for any late cancellations/no-shows as insurance does not cover these fees/charges.

___ 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.

___ Privacy Policy Notice: I acknowledge that I have reviewed a copy of the Notice of Privacy Practices (All documents are available for review at front desk.).

___ Office Policies and Procedures Notice: I acknowledge that I have reviewed a copy of the Office Policies and Procedures, Prescriptions and Refills Policies 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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CONSENT FOR RELEASE OF INFORMATION/HEALTH CARE COORDINATION FORM

Patient's Name: _____ Date of Birth: ___/___/___ Social Security Number: ___ - ___ - ___

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (___) _____ - _____ Mobile Phone: (___) _____ - _____ Email: _____

I hereby authorize Magnolia Psychiatry to release/receive the following health information:

_____ Initial Evaluation/Assessment
_____ Medical History and Information
_____ Psychotherapy Notes
_____ Office Visit/Progress Notes
_____ Complete Medical Record
_____ Psychological Reports & Testing Results
_____ Laboratory Results/Reports
_____ Billing Records/Information
_____ Transfer/Discharge Summary
_____ Other: _____

Please release the requested information for these treatment dates: _____

[ ] Records to be released to: [ ] Records to be requested/received from:

Name: _____ Relationship: _____

Health Care Provider Name: _____ Address: _____

Telephone Number: (___) _____ - _____ Fax: (___) _____ - _____

I acknowledge that I have the right to revoke this authorization in writing at any time by sending such written notification to the releasing person/agency. I understand that my revocation will not be effective to the extent that Magnolia Psychiatry has already taken action in reliance of this authorization or if this authorization was obtained as a condition of, obtaining insurance coverage and the insurer has the legal right to contest the claim. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be required as indicated in the copy of the Notice of Privacy Practices of Magnolia Psychaitry, that I have received and reviewed. I acknowledge that the authorized recipient may accomplish the re-disclosure of my protected health information and that Federal Privacy Rule will no longer protect it. I acknowledge and understand that I am waiving my right to confidentiality with respect to the information or records released pursuant to this consent and I hereby release Magnolia Psychiatry and its staff from any and all liability arising from the release and disclosure of the information or records. A photocopy or fax of this authorization is as valid as the original. Please note: This authorization will automatically expire one year from signing unless other date of expiration is specified here: _____

I acknowledge that I have read this authorization for release of information in its entirety and I fully understand its terms and implications. I freely, voluntarily and without and coercion, agree with the terms and conditions contained in this authorization.

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

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PATIENT HEALTH SCREENING INFORMATION AND MEDICAL/SURGICAL HISTORY:

EVENT	DATE

ALL CURRENT MEDICATIONS (MEDICAL AND PSYCHIATRIC):

NAME	DOSAGE

ALLERGIES/INTOLERANCES:

FAMILY HISTORY: Have you or any family members been treated for any of the following? Check all that apply.

ILLNESS	SELF	MOTHER	FATHER	AUNT	UNCLE	SISTER	BROTHER	CHILDREN	OTHER
ADHD/ADD									
ALZHEIMER'S									
ANXIETY									
BIPOLAR									
DEPRESSION									
HEART DISEASE									
SCHIZOPHRENIA									
SEIZURES									
STROKE									
SUBSTANCE ABUSE									
SUICIDE ATTEMPTS									

Care Team for patient_____ Date_____

Specialty	Clinician Name	Clinic Name	Phone number	Address	Reason being seen
Primary Care Provider					
		`			

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CONTROLLED SUBSTANCES AGREEMENT

(Please read carefully and sign for your medical record. A copy will be given to you upon request.)

I will use my medication(s) exactly as directed by my provider.

I will not allow or assist in the misuse/diversion of my medication(s); nor will I give or sell them to anyone else. All medication(s) will be obtained at one pharmacy, where possible. Should the need to change pharmacies arise, I will inform my provider immediately. I will use only one pharmacy and I will provide my pharmacist a copy of this form. I authorize my provider to release my medical records to my pharmacist as needed.

I understand that my prescription(s) and my medication(s) are specific to my plan of care. If my medications are either lost or stolen, replacement prescriptions may be given only with the proper documentation and will be done at the sole discretion of my provider(s). Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) may be allowed when I am traveling and arrangements are made with my provider(s) in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out

I will receive medication(s) only from ONE provider unless it is for an emergency or my provider approves the medication that be prescribed by another provider. Information that I have been receiving medication(s) prescribed by other providers that is not been approved by my provider may lead to a discontinuation of medication(s) and treatment.

If it appears to my provider that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my provider may try alternative medication(s) or may taper me off all medication(s). I understand that discontinuation of medications may cause withdrawal symptoms.

I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without warning. If I test positive for illegal substance(s), such as marijuana, cocaine, etc., this controlled substance treatment contract may be terminated.

I agree that I will inform any provider who may treat me for any other medical problem(s) that I am taking controlled substances, as the addition of other medication(s) may cause harm to me.

I will take the medication(s) as instructed by my provider. Any unauthorized change in the dose of medication(s) will be viewed as a cause for discontinuation of the treatment.

I will keep all follow-up appointments as recommended by my provider or my treatment may be discontinued.

I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and signing this form while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

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 healthcare practitioners 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) to allow for appropriate medical decision making by the practitioner.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. 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 personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions 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 or treatment.

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.
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.

<u>Patient Consent to The Use of Telehealth</u>

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)

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PRE-AUTHORIZED USE OF CREDIT CARD

DATE:_____

I authorize Magnolia Psychiatry to keep my signature on file and to charge my credit card during my course of treatment at Magnolia Psychiatry.

Charges include any payments that are patient responsibility including but not limited to: deductibles, copay, co-insurance and any non-covered or denied insurance payments.

Patient's Name:_____

Patient or Parent/Guardian
signature: _____

I authorize Magnolia Psychiatry to charge my credit card for any amount/fee owed to my credit card below.

Credit Card # _____

( ) Visa ( ) Mastercard ( ) Discover ( ) AMEX ( )Other

Expiration Date: _____ CVV (3-digit security code): _____
Billing zip code _____

Name on card: _____

Authorized Signature: _____

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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:** _____

Magnolia Psychiatry
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Cypress, TX 77429

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.

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:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 figety 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	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

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

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Debbie Edmunds, MA, LPC-S
Get it in gear with psychotherapy

H.O.P.E. Psychotherapy of Houston, PLLC
www.HopePsychotherapyOfHouston.com

Property Destruction/Inappropriate Behavior Agreement

At H.O.P.E. we strive to offer the most attractive, tranquil, healing and soothing environment possible while you and/or your loved one receives therapy. That is one of the things that separates us from many other clinics.

In order for us to accomplish this goal we need to make sure everyone respects other people here, the clinic and all property within and without. Unless everyone does his or her part H.O.P.E. cannot continue to be the environment that we feel sets us apart and that you know is a safe haven to come and improve your life.

Please read and sign below to indicate you understand your liability should property be damaged while you are here or behaviors become disruptive to the point others are inconvenienced and/or the therapy of another is interrupted.

I understand that I am responsible for the cost of any property including all marketing materials, giveaways, furniture of any kind, artwork, rugs/carpets/floor, walls, fountains, plants, etc. that is destroyed while I or my loved one receives therapy. The minimal fee for destroyed property is $25.00 to be paid prior to you leaving the clinic. The cost will increase per the owner's discretion based on the type and amount of property destroyed.

Patient (Please print)

Responsible Party Date

I understand that if while in the clinic my behavior or the behavior of my loved one becomes offensive and/or disruptive I/we may be asked to leave the clinic.

Responsible Party Date

Thanks for your help in keeping H.O.P.E. the place where people feel safe to return.

Debbie Edmunds, MA, LPC-S
Owner
and all other H.O.P.E. Clinicians

H.O.P.E. Psychotherapy of Houston, PLLC
17510 Huffmeister Rd., #101, #102 & 103
Cypress, TX 77429
281-373-5200 ofc.