Dr. Rosa C. Gonzalez
3560 Delaware Ste. 109 | Beaumont, Texas 77706
Office: 409-892-9347 Fax: 409-892-8803

PATIENT INFORMATION

Patient's Name: _____ SSN: _____
(First) (Middle) (Last)

Birth Date: _____ Age: _____ Occupation/School: _____ Grade: _____

Sex: ☐ Male ☐ Female ☐ Other_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other _____

Race: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other _____

Home Address: _____
(Street / RR Box # / Apt. #) (City/State) (Zip)

Preferred Number for Appointment Reminders: ☐ Home ☐ Cell ☐ Work **Email @ddress:**_____

Home Phone: _____ Mobile Phone:_____
(Area Code) (Area Code)

Employer:_____ Work Phone:_____
(Area Code) (Ext.)

PCP/Pediatrician:_____ Phone:_____
(Area Code)

Preferred Pharmacy:_____ Location: _____

**** Please email a copy of the Patients Insurance/Drug Card to drcookie@drcookiecares.com or Fax a copy to (409) 892-8803 ****

I give my consent to Dr. Rosa C. Gonzalez and staff to contact the following person in the event of an emergency.

Emergency Contact: _____ Phone:_____
(Area Code)

Relationship to Patient: _____

PARENT OR GUARDIAN INFORMATION

Parent's Name (1st): _____ Birth Date: _____ Social Security Number: _____

☐ Biological Mother/Father ☐ Step-Mother/Father ☐ Legal Guardian ☐ Adoptive Mother/Father

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other _____

☐ Medical Guardianship Documentation

Address (If different from patient's): _____
(Street / RR Box # / Apt. #) (City/State) (Zip)

Parent's Occupation: _____ Parent's Employer: _____

Parent's Preferred Contact Number: _____ Preferred Contact: ☐ Home ☐ Cell ☐ Work

Parent's Name (2nd): _____ Birth Date: _____ Social Security Number: _____

☐ Biological Mother/Father ☐ Step-Mother/Father ☐ Legal Guardian ☐ Adoptive Mother/Father

Address (If different from patient's): _____
(Street / RR Box # / Apt. #) (City/State) (Zip)

Parent's Occupation: _____ Parent's Employer: _____

Parent's Preferred Contact Number: _____ Preferred Contact: ☐ Home ☐ Cell ☐ Work

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other _____

☐ Medical Guardianship Documentation

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PATIENT ASSESSMENT QUESTIONNAIRE

Primary reason for the visit: _____

Have you seen a psychiatrist, therapist or counselor in the past? ☐ Yes ☐ No

If so, please provide name(s) and date(s): _____

Please list any medications & dosage taken for the following:

Anxiety: _____

Depression: _____

ADHD: _____

Sleep: _____

Other: _____

Please list any medication allergies: _____

Please list any medical conditions:
(Ex. seizures, thyroid, heart, head injury, etc.) _____

If Patient is a Child
List any problems during
Pregnancy or Delivery.
Birth Weight: _____
Were Milestones Normal?
☐ Yes ☐ No
(If No, Please Explain in Detail, ie;
Crawling, Sitting, Talking, etc.?)

FAMILY MEDICAL HISTORY

Family Members	Medical History	Psychiatric or Substance Use History
Mother Age: Still Living: ☐ Yes ☐ No		
Father Age: Still Living: ☐ Yes ☐ No		
Siblings Number: Ages:		
Children Number: Ages:		

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PRESENTING CONCERNS | ADULT

☐	Low energy/Fatigue	☐	Easily Distracted	☐	Depression
☐	Hopelessness/Worthlessness	☐	Poor concentration/Focus	☐	Sadness/Loss
☐	Guilt	☐	Racing/Recurring Thoughts	☐	Suicidal Thoughts
☐	Stress	☐	Anxiety/Nervousness	☐	Heart Pounding/Racing
☐	Anger	☐	Panic	☐	Seeing things not there
☐	Work Problems	☐	Excessive Worry	☐	Confusion
☐	Mood Swings	☐	Excessive Fear	☐	Memory Loss
☐	Loneliness	☐	Easily Frustrated	☐	Obsessive Thoughts
☐	Low Self Esteem	☐	Nightmares	☐	Compulsive Behaviors
☐	History of Abuse	☐	Avoid People	☐	Loss of Interest in Sex
☐	Parent/Child Relationship	☐	Lack of family/Social support	☐	Harms Self/Self-mutilation
☐	Relationship Problems	☐	Financial Stressors	☐	Hearing Voices
☐	Trouble Sleeping				
Other:					

PRESENTING CONCERNS | CHILD or ADOLESCENT

☐	Negative Self-Image	☐	Counseling in the Past 2 years	☐	Destroys Things
☐	Child Verbally/Mentally Abused	☐	No Guilt for Misbehaving	☐	Lies Frequently
☐	Child Physically Abused	☐	Criminal History	☐	Sad/Unhappy/Depressed
☐	Child Sexually Abused	☐	Harms Self/Self-Mutilation	☐	Soils Bed or Clothing
☐	Sudden Mood Changes	☐	Poor concentration/Focus	☐	Wets Bed or Clothing
☐	Fatigue/Lack of Energy	☐	Easily Distracted	☐	Developmental Delays
☐	Suicidal Thoughts	☐	Poor School Relationships	☐	Limited Mental Ability
☐	Suicidal Attempts	☐	Poor Relationship w/Parents	☐	Limited Physical Ability
☐	Steals	☐	Poor Relationship w/Siblings	☐	Limited Communication Skills
☐	Disregards Rules at Home	☐	Child acts Fearful/Anxious	☐	Trouble Sleeping
☐	Social Isolation/Withdrawal	☐	Violence in Family	☐	Currently Failing Grades in School
☐	Substance Abuse	☐	Anger		
☐	Verbally/Physically Threatens Others	☐	Uses Tobacco/Nicotine Products		
Other:					

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR SLEEP

- Do you have trouble falling asleep at night?
  ☐ Yes ☐ No
- Do you wake up in the middle of the night and have trouble falling back asleep?
  ☐ Yes ☐ No
- Do you wake up too early in the morning?
  ☐ Yes ☐ No
- Do you feel unrested when you wake in the morning?
  ☐ Yes ☐ No
- How long have you experienced trouble with sleep?
  ☐ Less than 1 Month ☐ 3-6 Months
  ☐ 1-3 Months ☐ 6 Months or More
- How many nights a week do you have trouble sleeping?
  ☐ 1-2 Nights ☐ 3-4 Nights
  ☐ 5-6 Nights ☐ Every Night

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CONSENT TO TREATMENT

I request and authorize **Rosa C. Gonzalez M.D. P.A.,** and those employees who may provide services during my treatment to perform routine tests and procedures and to provide certain services as prescribed for my health and well-being in accordance with applicable laws and regulations. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by **Rosa C. Gonzalez M.D. P.A.**, nor have I relied upon any such representations, warranties, or guarantees.

_____ _____
Patient Signature or Legal Guardian Signature (If patient is a minor.) Date

If signed by Legal Guardian, state relationship to patient: _____

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received a copy of the **Rosa C. Gonzalez M.D. P.A.,** Patient Information Packet, which includes but is not limited to the Notice of Privacy Practices. I understand that I may obtain a written copy of this Notice at any time upon request.

_____ _____
Patient Signature or Legal Guardian Signature (If patient is a minor.) Date

MEDICAL PHOTOGRAPHY

I hereby consent to the taking of a photograph of me by **Rosa Gonzalez M.D. P.A.** I understand that my photograph may be used to assist with identification and treatment. Other than for treatment and identification reasons, images that identify me will not be released to any outside entity unless requested by me or my legal representative.

_____ _____
Patient Signature or Legal Guardian Signature (If patient is a minor.) Date

FINANCIAL AGREEMENT (REQUIRED)

By signing below, I acknowledge that I have received a copy of Rosa Gonzalez M.D. P.A., financial policy, and hereby agree to comply with the requirements in the Policy.

_____ _____
Patient Name DOB

_____ _____
Responsible Party (please print) Responsible Party's SS#

_____ _____
Relationship to patient Responsible Party's DOB

_____
Address (Street / RR Box#) (City/State) (Zip)

_____ _____
Home Phone Work Phone

_____ _____
Signature of Responsible Party Date

A Release of Information may be required if the Responsible Party is someone other than client
***** Patients who are 18 or older will need to sign a permission slip to allow case discussion with a parent. If you want your case discussed with anyone else, you will need to have a signed permission slip on file for that person.***

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Financial & Billing Policy

Rosa C. Gonzalez M.D. P.A. accepts payments by cash, check, credit card or money order. As a courtesy to our patients, the responsible party may leave a card on file to be charged for appointments.

We DO NOT ACCEPT Medicare, Medicaid, CHIP, Medicaid Contract Providers, or Insurance ACO's, PPO's, etc.

- Payment is ***required*** before time of service. **Rosa C. Gonzalez M.D. P.A.** is not contracted and not able to file insurance claims to Medicare, Medicaid, or any private insurance.
- The client or legal guardian will be required to sign a financial agreement documenting their understanding of the above item.

Appointment Charges & Medication Checks **Initial _____**

- Initial visit is **$500.00**. A **$500.00** deposit is required upon scheduling and only **$250.00** is refundable, with 48-hours notice.
- Medication checks are scheduled for 15-20 minutes and are **$250.00** per appointment.
- If your appointment extends beyond 20 minutes the charge will be **$300.00 or more** depending on actual times.
- In order to be seen during the entire session, please be prompt for your appointments.
- If you have not been seen in close to a year or over, it will be considered a new office visit and a fee of **$500.00** will be charged. *****This pricing schedule is subject to change.*****

Missed Appointments and Late Cancellations **Initial _____**

- Our office will call or text to remind you, as a courtesy, (2) business days before the date of your appointment.
- It is ultimately your responsibility to keep up with your appointments as we may not be able to reach you.
- If you are more than 15 minutes late for your appointment it will be considered a no-show and you will be charged the no-show fee of **$250.00** and your appointment will be rescheduled.
- Missed appointments or cancellations made less than 48-hours in advance of the scheduled appointment will be charged to the patient's account at 100% of the fee of the missed appointment.
- After the first missed or late cancelled appointment, a valid credit card is required to be put on file prior to scheduling the second intake appointment. *Your credit card will not be charged unless the second appointment is missed or cancelled less than 48-hours of the scheduled appointment.
- Payment in advance is required to hold an appointment on a provider's schedule.

Emergency Services **Initial _____**

- I agree to contact 911 or go to the nearest hospital if I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

Paging the Doctor **Initial _____**

- There is a 24-hour paging service for EMERGENCY situations.
- There will be a **$150.00** fee for afterhours calls that last between 1 and 15 minutes. Calls over 15 minutes will be charged the same as a medication checks at **$250.00** per call.
- **Office Hours are Mon-Thur from 9:00 A.M to 5:00 P.M. and our lunch hour is 12:00 P.M. to 1:30 P.M.**

Miscellaneous Services and Fees **Initial _____**

Rosa C. Gonzalez M.D. P.A. is eligible to charge the state-accepted fees for copying records, letter writing, filling out extensive forms, legal services, or other miscellaneous provider services.

Patient Information Updates **Initial _____**

- I agree to notify **Rosa C. Gonzalez M.D. P.A.** office of any address or phone number changes.

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Female Patient Information & Updates **Initial _____**

- If taking medications, I agree to notify **Rosa C. Gonzalez M.D. P.A.** in the event that I am planning to become pregnant or become pregnant so that I may discuss the risks/benefits of medications.

Alcohol, Drugs or Herbal Supplements **Initial _____**

- It is recommended not to use alcohol, drugs or herbal supplements in combination with prescription psychiatric medication and I agree to notify **Rosa C. Gonzalez M.D. P.A.** if this is a concern.

Payment Arrangements **Initial _____**

- Payment arrangements will not be accepted for initial visits.
- The responsible party is required to make payment arrangements at least 24 hours prior to the appointment.
- The responsible party is required to maintain financial compliance with the terms stated in the promissory note. If financial compliance is not maintained, the account will be turned over to our collection agency.

Minors & Patients with Divorced Parents **Initial _____**

- Concerning minor children, the individual bringing the child in will be responsible for payment at the time of service.
- Financially responsible parties who are unable to attend the appointment are encouraged to put a credit card on file so that payment can be collected.

Outstanding Balances **Initial _____**

- Unpaid balances remain the responsibility of the individual who signed the **Financial Agreement**.
- Account balances due after 60 days from the date of service will prompt the account to be reviewed for collections.
- Once an account has been turned over to our collection agency, the responsible party must resolve the balance with the agency.
- Financial noncompliance could result in the client receiving a 30-day discharge notice from **Rosa C. Gonzalez M.D. P.A.**
- When the collection agency is engaged on the account, the responsible party will be liable for any interest that may be added at the current legal rate and for any attorney fees required to collect for services.

Returned Checks **Initial _____**

- Checks returned for insufficient funds will result in a **$35.00** charge to the client's account.
- If **Rosa C. Gonzalez M.D. P.A.**, receives two checks for insufficient funds from the same responsible party, that responsible party will be required to make all future payments by cash, credit card or money order.
- Post-dated checks will not be accepted without prior authorization.

CREDIT CARD AUTHORIZATION (OPTIONAL)

I authorize **Rosa C. Gonzalez M.D. P.A.,** to charge the credit card provided below for services rendered, including deductibles and co-pays. This authority expressly authorizes any and all future charges and is to remain in full force and effect until **Rosa C. Gonzalez M.D. P.A.,** has received a 30-day written notification from the undersigned of any modifications to this credit card authorization. I also agree not to dispute any charges to the credit card after sixty (60) days from the date of the charge.

By signing this Authorization, I certify that all information provided below is true and accurate.

_____ _____ _____
Credit Card # Expiration Date V-Code

_____ _____
Signature of Cardholder Date

Clients may be asked to periodically update and sign **Rosa C. Gonzalez M.D. P.A.,** Financial Agreement annually

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PRESCRIPTION MEDICATION, REFILL & CONTROLLED SUBSTANCE POLICY

Controlled substance medications (ADHD meds, amphetamines, benzodiazepines, tranquilizers) are very useful but have a high potential for misuses and are therefore, closely controlled by local, state and federal governments. They are intended to help calm and help people focus, thus improving function and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my mental health, I agree to the following conditions:

Prescription Medication & Refill Policy **Initial _____**

- I understand that most medications used for children/adolescents are not FDA approved. I also understand that antidepressants may cause suicidal ideations and that if I approve of Dr. Gonzalez prescribing an antidepressant, I will need to monitor and report any mood changes, suicidal comments or other unusual behaviors.
- Medication is prescribed to last until your next appointment. You will need to be seen **at least** every 3-4 months.
- You must be seen in at least 3-4 month intervals in order to continue to get refills. This may be more frequent for new patients if requested by the doctor.
- Please call during office hours to request refills. No prescriptions will be ordered outside of office hours.
  - **Office Hours are Mon-Thur from 9:00 A.M to 5:00 P.M. and our lunch hour is 12:00 P.M. to 1:30 P.M. Excluding Holidays**
  - **Please use our convenient Patient Portal to request medication refills at www.drcookiecares.com/patient-portal .**

Controlled Substance Policy **Initial _____**

- I am responsible for controlled substance medications prescribed to me. I understand that if a prescription is misplaced, stolen, or if I "run out early" Dr. Gonzalez will not replace the prescription. Further, all prescriptions will be refilled based on the previous prescription date and not based on the date the prescription was filled by the pharmacy.
- The doctor may require random drug screenings. The patient must be compliant with all drug screenings to be eligible to continue treatment.
- Refills of controlled substance medications:
  - Will be made only during regular office hours Monday-Thursday (excluding holidays)
  - Will NOT be made as an "Emergency", will require at least 48 hours in advance.
- I understand that if my doctor feels that I am at risk for psychological dependence (addiction); my medication will no longer be refilled.
- I understand that if I violated any of the above conditions my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance and medications from another individual, or the concomitant use of non-prescribed illicit (illegal) drug, I may also be reported to all my physicians, medical facilities, and appropriate authorities.
- I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given medication to help me reach my goal, I agree to help myself by the following better health habits: exercise, weight control, and avoidance to tobacco and alcohol. I must also comply with the treatment plan prescribed by my physician.
- I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

I have read this contract and I fully understand the consequences of violating this agreement may result in the termination as a patient from this practice.

_____ _____

Patient Signature or Legal Guardian Signature (If patient is a minor.) Date

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CONSENT TO PARTICIPATE IN PSYCHIATRIC CARE IN PERSON OR VIA TELEMEDICINE

1. I understand that I will be seeing a health care provider in person or via telemedicine.

2. It has been explained to me how the video conferencing technology will be used.

3. I understand that if I participate in telemedicine, I will not be in the same room as my health care provider.

4. I understand there are potential risks to telemedicine technology including:
    a. Delays in medical evaluation and treatment may occur due to defiencies or failures of the equipment.
    b. Information transmitted may not be sufficient (poor resolution of video or audio) to allow for appropriate medical decision making by health care provider.
    c. Security protocols can fail, causing a breach of privacy of my confidential medical information even though the system is secure, and it is almost impossible for anyone to access the communication.
    d. A lack of access to all of the information that might be available in a face-to-face visit, which is not available in a telepsychiatry session may result in errors of medical judgement.

5. I understand that my health care provider or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation, or if the health care provider decides the patient requires a face-to-face evaluation with the health care provider in the same room with the client.

6. I understand that there are benefits to using telemedicine including:
    a. Client convenience.
    b. Increased accessibility to psychiatric care where a care provider would not normally be available.
    c. Ability to see a health care provider more rapidly with faster symptom relief.
    d. In some cases, clients may be more comfortable talking to a health care provider over telemedicine than in the same room.

7. I understand that if I am not in a private location while accessing telemedicine, others may see or overhear my protected health information. I thus hereby consent and authorize Rosa C. Gonzalez, M.D. to disclose my protected health information to her telemedicine provider or to anyone present with me when I access Rosa C. Gonzalez, M.D.'s telemedicine service through Rosa C. Gonzalez, MD PA. to use the telemedicine services for the purpose of my treatment. This consent and authorization will remain in place until revoked by me. I may revoke this authorization at any time by contacting Rosa C. Gonzalez, MD PA. The terms of my service with Rosa C. Gonzalez MD PA will not be affected if I choose not to sign this consent and authorization.

8. I have had the alternatives to a telemedicine consultation explained to me and in choosing to participate in a telemedicine consultation I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of Rosa C. Gonzalez, M.D.

9. I understand that no part of the consultation in person or online will ever by recorded or photographed.

I have read this document carefully and understand the risks and benefits of telemedicine consultations or visits and have had my questions regarding the procedure explained. I hereby consent to participate in a telemedicine visit under the terms described herein.

CONSENT FOR PSYCHOTHERAPY

I understand omitted information or untrue information presented to the provider or staff of Rosa C. Gonzalez MD PA in my history, symptoms, behavior, or other health information could compromise my treatment and my health. I will make every effort to be truthful and clear with the provider and staff of Rosa C. Gonzalez MD PA.

I give consent for the provider and staff of Rosa C Gonzalez MD PA to communicate with my primary care provider, counselor, therapist, or other medical specialist who care for me, and my pharmacy to best coordinate my health care needs.

The undersigned client | parent | legal guardian | conservator voluntarily consents to and authorizes service as considered necessary by Rosa C. Gonzalez, M.D. These services may include psychiatric care, medical care, psychotherapy, medication, laboratory test, diagnostic procedures, referrals, or other appropriate treatments.

The undersigned also acknowledges that Rosa C. Gonzalez, M.D. **DOES NOT PRESCRIBE CONTROLLED SUBSTANCES FOR CHRONIC PAIN MANAGEMENT** (she will refer to pain management to assure appropriate treatment for such condition).

Further, I understand I may be asked to submit to drug screening as part of my care and that the provider is able to review my narcotics prescription history on the Texas Prescription Monitoring Program website. I further consent to the release of my prescription drug history from pharmacies when necessary.

The undersigned understands that he or she has the right to:

1. Be informed and participate in the selection of treatments.

2. Receive a copy of this consent.

3. Withdraw this consent at any time.

PATIENT PRINTED NAME: SIGNATURE (Patient or Legally Authorized Representative):

DATE:

Rosa C. Gonzalez, M.D., P.A.
3560 Delaware, Suite 109
Beaumont, Texas 77706
Phone:409-892-9347
Fax:409-892-8803

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and me, Rosa C. Gonzalez, M.D. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When I examine, diagnose, treat, or refer you. I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let me use your information here and send to others. This Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this Consent form.

Please Note: If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, I cannot treat you.

In the future I may change how I use and share your information and so may change our Notice of Privacy Practices. If I do change it, you can get a copy by calling me at (409)892-9347 during office hours.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me that you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some information and cannot change that.

_____ _____
Signature of client / or parent or guardian Date

_____
Printed Name of client / or parent or guardian

_____ _____ _____
Relationship to client Witness Date

Date of NPP _____ Copy given to the Client / Parent / or Guardian ____

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or health care operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the protected health information for treatment, payment, or health care operations.

By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usuage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

a. Protected health information may be disclosed or used for treatment, payment, or health care operations.

b. The Practice reserves the right to change the privacy policy as allowed by law.

c. The patient has the right to restrict the use of the protected health information, but the Practice does not have to agree to those restrictions.

d. The patient has the right to revoke this consent in writing, at any time, and all full disclosures will then cease.

e. The Practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm your appointments? ◯ **YES** ◯ **NO**

May we leave a message on your voicemail at home or on your cell phone? ◯ **YES** ◯ **NO**

May we discuss your medical condition with any member of your family? ◯ **YES** ◯ **NO**

If YES, please name the members allowed: _____

This consent was signed by: _____
PLEASE PRINT NAME

Signature: _____ Date: _____

Witness: _____ Date: _____