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 Contact Number for Appointment Reminders: ☐ Home ☐ Cell ☐ Work

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

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

Physician or Pediatrician: _____ Phone:_____
(Area Code)

Preferred Pharmacy: _____ Location: _____

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

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Financial & Billing Policy

Rosa C. Gonzalez M.D. P.A. accepts payments by cash, check, credit card or money order (AMEX not accepted)**. As a courtesy to our patients, the responsible party may leave a card on file to be charged after services are provided.**

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

- Payment is ***required*** at time of service. **Rosa C. Gonzalez M.D. P.A.** is not contracted and not able to file insurance claims to Medicare, Medicaid, or Medicaid Contract Providers.
- 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 $400.00. A $200.00 deposit is required upon scheduling and is only refundable with 48-hours notice.
- Medication checks are scheduled for 15-20 minutes and are **$200.00** per appointment.
- If your appointment extends beyond 20 minutes the charge will be **$275.00 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 **$400.00** will be charged.

*****This pricing schedule is subject to change.*****

Missed Appointments and Late Cancellations **Initial _____**

- Our office will call 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 **$200.00** and your appointment will be rescheduled.
- Missed appointments or cancellations made less than 24-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 24-hours of the scheduled appointment.
- Payment in advance will be required to hold an appointment on a provider's schedule after the 2nd late cancelled or missed appointments.

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 **$100.00** 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 **$200.00** 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 at time of service. Also, financially responsible parties can call the day of the appointment to make a payment.

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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MEDICATION REFILL & CONTROLLED PRESCRIPTION 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:

Medication Refills

- 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-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.**

Controlled Substance Refills

- I am responsible for controlled substance medications prescribed to me. If my prescription is lost, misplaced, stolen, or it I "run out early" I understand that it will not be replaced.

- 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