Round Rock Psychiatry
www.roundrockpsychiatry.com
512-550-1715

New Patient Registration

Please Print Legibly:

Patient's Name ____

□ Male □ Female □ Preferred pronouns_____________ Date of Birth (month/day/year) _____________

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Other ________________________

Home Tel. # (________) __________________________ Cell # (________) ________________________

Mailing Address ____

City ____ State _________________ Zip ______________

Email ____

Physical Address (ONLY If different than mailing address)

____

City____________________________________ State_____________________ Zip __________________

Occupation ____ How Long? _______________

Highest Education Level ____

Primary Care Doctor ____

Primary Care Doctor's Telephone # if known ____

Primary Emergency Contact Name ________________________________ Tel # ____________________

Secondary Emergency Contact Name ______________________________ Tel # ____________________

Have you had previous psychiatric treatment or hospitalization? □ Yes □ No

If yes, where

1. ____ When _____________________
2. ____ When _____________________
3. ____ When _____________________

Have you had previous chemical dependency treatment (detox, rehab, etc.)? □ Yes □No

1. ____ When _________________________
2. ____ When _________________________
3. ____ When _________________________

Most Recent Psychiatrist __________________________ How long _________ Last seen ____________

Most Recent Therapist _____________________________ How long _________ Last seen ____________

Briefly, why are you seeking help today?

____

____

____

____

____

____

Please list all **current prescription medications** (include dose, frequency, and when first started):

____

____

____

____

____

____

Please list all known medication allergies:

____

____

Patient’s Signature ____

Today’s Date ______________________

Patient's name____

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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FEE SCHEDULE

I. INITIAL DIAGNOSTIC EVALUATION: 75 MINUTES	**$300**
II. FULL FOLLOW UP: 30 MINUTES **This appointment type is for medication management that includes light psychotherapy, or for more in-depth conversation regarding medication adjustment.	**$150**
III. MEDICATION CHECK-IN: 10 MINUTES **This appointment type is for 90 day follow up appointments, refill requests or for uncomplicated medication adjustments.	**$75**
IV. PSYCHOTHERAPY: 50 MINUTES ** This appointment type includes personal, partner, and/or family counseling sessions.	**$200**
V. MISSED APPOINTMENT **Fee is charged for any cancellation with less than 24-hour notice or missed appointment.	**FULL FEE**
VI. ADMINISTRATIVE FORM FEES **Fee is charged for each individual request of letters (including ESA or any other type), forms (including FMLA, disability, etc.), or documents of any type.	**$100**
VII. MEDICAL RECORDS REQUEST **$25 for the first 20 pages & 50 cents per page thereafter.	**$25 MINIMUM**
VIII. TELEPHONE CONSULTATION	**$25 PER 5 MINUTES**

PLEASE NOTE:

1. APPOINTMENT FEES ARE DUE **AT THE START** OF THE APPOINTMENT
2. TELEPSYCHIATRY APPOINTMENT FEES ARE **THE SAME** AS IN-OFFICE APPOINTMENTS
3. A SUPER BILL MAY BE PROVIDED TO YOU FOLLOWING YOUR APPOINTMENT. YOU MAY CHECK WITH YOUR INSURANCE CARRIER FOR REIMBURSEMENT OF 'OUT OF NETWORK' PHYSICIAN APPOINTMENTS. REIMBURSEMENT FOR OUT OF NETWORK APPOINTMENTS IS THE RESPONSIBILITY OF THE PATIENT; HOWEVER, THE CLINIC WILL OFFER ANY REASONABLE ASSISTANCE.

NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.** This information is required under the Health Insurance Portability and Accountability act (HIPAA) passed by congress in 1996.

"I" and "my" refers to Israel C. Calzada, MD.

I. Uses and Disclosure for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations" - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychiatrist. Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are business-related matters such as audits and administrative services and care coordination.
- "Use" applies only to activities within my clinic such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of clinic such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosure Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment and health care operations when your documented authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing.

III. Uses and Disclosure with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must take a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, The Texas Youth commission, or to any local or state law enforcement agency.
- Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety: If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- Worker's Compensation/FMLA: If you file a worker's compensation claim or file for FMLA, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Psychiatrists' Duties

YOU have a right to:

- Right to Request Restrictions -- You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request but will make every effort to accommodate you.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations -- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- Right to Inspect and Copy -- You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. Request for records will be completed within 30 days of request (see fee schedule for fees regarding records requests).
- Right to Amend -- You have the right to request an amendment of PHI for as long as the PHI is maintained in the record, I may deny your request. On your request, I will discuss with you the details of the amendment process. Again, I will work to accommodate your request.
- Right to a Paper Copy - You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

Psychiatrists' Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you advance notification and/or with a written or electronic copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy right, you may contact me at 512-550-1715.

If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to me at 1970 Rawhide Dr, Suite 318, Round Rock TX 78681.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.
I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date of Privacy Policy: July 1, 2017.

By signing below, you attest that you have received a copy of this document.

Patient's Signature ____ Date ____________________

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Consent to Treatment with Psychoactive Medication Information Sheet

Consumer's Rights Under the Consent to Treatment with Psychoactive Medication Rule

General Information Regarding Rights and Consent:

You have the right to decide whether to take this medicine as recommended by your doctor. You can agree to take the medicine; this agreement is called "consent." You have the right not to agree to take this medicine. If you do not agree to take or if you object to taking the medicine, your objection will necessarily be documented in your medical file. You have the right to withdraw your consent to treatment with psychoactive medications at any time.

There may be a person who is authorized to agree or object for you. That person is called your "legally authorized representative." Your "legally authorized representative" can be a person appointed by a court to look after your well-being, usually called a guardian. No other person can consent or object for you.

You have the right to know what may happen if you do not choose to take the medicine.

You have the right to be informed about, and to discuss with your doctor, other types of treatment your doctor thinks can reduce or control your symptoms and help you feel better. You have the right to know how the medicine will be given to you, how frequently and for how long it will be given to you.

You have the right to know that all medicines have side effects; some are mild and some severe. Some side effects may be permanent. You have the right to know this before agreeing to the medication or making your objection to taking the medicine.

You have the right to know what side effects might occur if you take the medicine. You have the right to know which side effects you, as an individual, may likely experience. You have the right to know what kind of permanent problems may occur because of taking this medicine for a long time or in a large amount.

You need to immediately tell your doctor or the staff if you have any problems while taking the medicine. You should always tell your doctor or the staff about any other medicines you are taking or are allergic to. After these things have been explained to you, you still have the right to object to the medication. In case of a medical emergency please do not take the time to call the clinic; rather, call 911 or immediately present yourself at the nearest urgent care clinic.

If your medication and/or group(s) of medicine is to be changed or the way of taking the medicine is to be changed, you again, have the right to be informed of the change. Information should be given to you about any new medicine or any change in your medication including how it will be given to you (pill, liquid, or injection), how much you will receive at one time, and when you will receive the medication.

Patient's Signature ____ Date ____________________

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Round Rock Psychiatry Office Policies

We appreciate the opportunity to serve you and we have developed office polices that facilitate the delivery and quality of care to all of our patients.

Appointments

1. In consideration of all patients, **individuals who arrive more than 5 minutes late may constitute a missed appointment and need to reschedule**. At the discretion of staff, this policy may be waived on a case-by-case basis and/or allow an abbreviated visit. If you are running late, please let us know as early as possible. Please make every attempt to arrive approximately 10 minutes early to allow time for payment and other applicable administrative requirements.

2. **Cancellations of scheduled appointments should be made with 24 hours prior notice to avoid a full fee charge.** If a scheduled appointment is cancelled or rescheduled with less than 24 hours of notice the full fee will be required. There is no cost for cancelling or rescheduling an appointment prior to 24 hours before your appointment.

3. **Three no-shows or late cancellations in a 9 month period of time may result in the termination of our professional relationship.**

4. Although staff may confirm appointments in advance, it is the responsibility of the patient to attend follow-up appointments. Follow-up appointments may be scheduled after each visit in order to foster continuity of care and availability.

5. Patients are encouraged to make or move up an appointment when a complaint or problem occurs with regard to their mental health. **Please reserve telephone inquiries to Dr. Calzada for issues that can be reasonably managed by a 5-10 minute phone call. If longer, then scheduling an appointment is recommended. There is a charge for evaluation or management done over the phone if call length is 5 minutes or longer (see Fee Schedule, Telephone Consultation).**

6. It is the responsibility of the patient **to inform the clinic of any changes** in address, email or phone number. Please review this information at least annually.

7. **When possible, please do not bring children to the appointments** that cannot sit in a waiting room alone safely and quietly. We reserve the right to refuse service if we deem the child too young to sit in the waiting room alone.

8. **Telepsychiatry**: We are pleased to offer telepsychiatry (online) services to our patients as allowed by state and national laws. This service is provided as a convenience to our patients at the **same fees as in-office appointments**; this service allows you to complete your appointments with Dr. Calzada in any location of your choosing. All first-time patients receiving an initial evaluation may be required to be seen in-office before qualifying for telepsychiatry services. Please review the Telepsychiatry Consent Form for more details.

Payments

1. **Payments and balances are due at the start of your appointment**. Alternatively, payments may be made over the phone in advance. You can choose whether to receive your receipt via email or in-office hardcopy. If you cannot pay at the time of your visit, you will be asked to reschedule.

2. For your convenience, and at your request, we may keep a credit card on file (requires signed authorization for each new card) to minimize time in office. Your receipt may be emailed to you or provided to as a hardcopy in office. This service is especially convenient for telepsychiatry services. Contact the office to request a Credit Card Charge Authorization form or download a copy from www.roundrockpsychiatry.com.

3. We reserve the right to discontinue our professional relationship if a balance is not resolved.

4. Although our staff may assist with reasonable requests, the patient is solely responsible for any reimbursement for out of network benefits. We will provide you with a super-bill that you may present to your insurance company for 'out of network' reimbursement.

Forms and Refill Requests

Dr. Calzada will typically provide enough medication to last until your next appointment. It is the responsibility of the patient to personally call in to the office and request a refill (this may also be done via email). Five business days prior to running out of medication is recommended. Call your pharmacy for available refills before calling the clinic, this process may reduce the chance of error. Be sure to verify the pharmacy has our correct contact information and are aware we are on **E-prescribe.**

1. Texas law requires patients to be under medical supervision when taking controlled medication. **You may be required to see a clinician before your medicine is refilled if you have missed your prior appointment(s) and/or in order to determine medical necessity.**

2. If a patient is going to run out of medicine within 48 hours, or has already run out (late refill request), the patient may call the office to request the clinician to call it in to the pharmacy. This event should typically not occur as you will be provided enough medication through your next appointment.

3. **Forms (including disability, FMLA and other reports**) may require a separate appointment in order for the clinician to gather information specific to the form from the patient. An appointment fee (10 or 30 minutes) is typical for the research, completion and delivery of forms. **Our philosophy and goal is to return employees on leave or disability back to normal functioning and work status as soon as possible, this may include recommendation for Intensive Outpatient (IOP) during leave.**

4. **Schedule II Controlled Substances (C-II) medications such as stimulants** require as a general rule an appointment. **These prescriptions have an expiration of 21 days**, including transit time and processing at mail-order pharmacies. If the patient loses a prescription or med bottle, allows a prescription to expire, or spontaneously increases the dose, **an appointment may be required** to monitor compliance and medical necessity with these more controlled C-II

medications before a new prescription is issued. Monitoring appointments of patients taking C-II prescriptions as a rule, is **no less often than quarterly**. **Lost or expired scripts will require a 10-minute appointment to replace.**

5. **Benzodiazepines:** These include brand names such as Xanax, Klonopin, Valium and Ativan. Dr. Calzada, as a policy, does not regularly start these medications as their potential for harm far outweighs their benefit. Please keep in mind prior to making your appointment that only in very specific circumstances will Dr. Calzada provide benzodiazepines and will, in no circumstances provide long term use. If you are already using benzodiazepines, Dr. Calzada will work to provide you a safe and professional taper to discontinue the medication for the benefit of your health.

After-hours Resources

- Services will be provided to the patient within normal business hours. We do not check emails or phone messages after business hours or on weekends. If you call during our operating hours, we will respond to your call or email within 24 hours.
- **In case of an emergency, the patient should not call the Round Rock Psychiatry clinic; instead, call 911 for medical emergencies or (512) 472-HELP for the suicide hotline for Travis County. Also, you may go to a local Emergency Room, urgent care clinic or psychiatric hospital (or any combination of the above.) Please see our website Resources at www.roundrockpsychiatry.com**
- **Psychiatric Hospitals:** Shoal Creek Hospital: (512) 324-2000 Austin Lakes Hospital: (512) 544-5253. Psychiatric Emergency Department: (512) 324-7000 Georgetown Behavioral Hospital: (877) 500-9151 Rock Springs: (512) 819-9400
- Two alternative options if you run out of medication: **1. Urgent Care Centers** may be a resource for short-term refills (bring your empty bottle) and **2. Pharmacies** can dispense a 3-day (a.k.a. "loaner") supply at their discretion.

Compliance

1. It is our hope and expectation that patients are motivated to work towards improving their mental health.
2. It is the responsibility of patients to comply with mutually agreed-upon treatment plans and recommendations from the clinician (treatment alliance and therapeutic relationship).
3. Repeated instances of non-compliance (failure to get labs, failure to follow-up with therapists, self-medicating, and others) will be considered potentially hazardous and a violation of office policy. This may result in termination of the patient-physician relationship.
4. Treatment is based on the informed consent of the patient. If you have any questions or concerns regarding medications or other aspects of treatment, please query your provider. Do not consent to any medication or other intervention before considering yourself adequately informed.

Behavior

1. We understand that patients experience many difficulties as a result of mental health problems or other reasons and we strive to provide the best outpatient service for our patients. However, if at any point staff or clinicians feel threatened by an individual, this may be cause for immediate termination of our professional relationship. Threatening behavior includes (but is not limited to) direct or indirect threats towards staff or other patients, lewd behavior, **verbal abuse**, yelling or physically damaging property. **Please be civil at all times.**

2. Deliberately misleading staff or clinicians may be grounds for termination of our professional relationship, depending on the circumstance.

Confidentiality

1. The clinic understands the need to keep your matters confidential, and we will act in good-faith to maintain your matters private. Please use caution in leaving us home or work numbers to call you back, as leaving an email, voice message or conversing may jeopardize your confidentiality if other people share your voicemail or email. Please keep you contact information current.

2. Staff or physicians may require a release in order to speak to family members or other providers, unless the clinic believes in good faith there is an emergency and it serves your best interests (principle of beneficence). Please ask the office staff for releases for anyone you would like to have access to your information ahead of time or download the Release of Information form at www.roundrockpsychiatry.com.

3. Certain 3rd party payers, labs, courts and other entities industry may need access to some of your protected health information (PHI). Please see HIPAA statement. While patient confidentiality is protected and highly valued, exceptions to physician-patient confidentiality do exist pursuant to state and federal law.

Severe or repeated violations of office policy may result in a discontinuation of our professional relationship. If the patient doubts the validity of violation, he/she can contact our office to discuss. You reserve the right to end our professional relationship at any time. We look forward to serving you!

This Office Policy may be updated in the future without notice, however a current copy can be requested at our office, by mail or fax, free of charge. If any policy is in conflict with state, local or federal law, that policy or portion of that policy will be considered null and void.

By signing, you attest: “I have received a copy of Round Rock Psychiatry - Office Policies (effective January 1, 2019)”

Signature ____ Date ______________________

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CONTROLLED SUBSTANCE AGREEMENT:

The following agreements are made between the Patient and Physician, as identified above, and outlines the duties and expectations of each party and will be considered a binding agreement. This agreement will be part of the patient's medical records.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

- This Controlled Substance Agreement relates to my use of any and all prescription medication(s) to manage my condition as prescribed by my physician.
- All medication(s) and prescriptions for the treatment of my condition will be obtained from **only** my physician.
- Medication(s) for the management of my condition will be provided by my physician so long as I follow the rules, terms and conditions specified in this agreement. Failure to comply with any of the rules, terms, and / or conditions of this agreement may result in discontinuation of the medication(s) and / or my discharge from my physician's care and treatment.
- Discharge from my physician's care and treatment may be **immediate** for any criminal behavior.
- I will use the medication(s) exactly as directed by my physician.
- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued by my physician. Please keep in mind that should Dr. Calzada prescribe a Benzodiazepine it will be with the philosophy of using the **lowest effective dose** for the **shortest amount of time** that he deems medically necessary.
- Use of illegal substances, alcohol, and other mood altering drugs can lead to dangerous side effects. I agree to submit to urine and / or blood screens to detect the use or non-use of non-prescribed and prescribed medication(s) at any time and without prior warning on less than 24 hour notice. Any evidence of use of illegal substances may lead to discontinuation of the medication(s).
- Dr. Calzada may at any time choose to discontinue the medication(s) for the treatment of my condition typically based off a risk versus benefit analysis.
- I will disclose to my doctor all other medication(s) that I take at any time, prescribed by any doctor other than my physician.
- I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am taking medication(s) for the management of my condition since the use of other medication(s) may cause harm.

- I will not share, sell or otherwise permit others, including my family and friends to have access to my medication(s).
- I will keep my medication(s) and prescriptions in a secure place to prevent theft or loss. I will not allow or assist in the misuse / diversion of my medication(s); nor will I give or sell them to anyone else. Lost or stolen medication(s) and / or prescriptions may not be replaced.
- I agree not to obtain or seek to obtain any other medication(s) from any other source without first contacting my physician. Information that I have been receiving other medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of the medication(s) and treatment.
- I understand that the State of Texas tracks information provided by pharmacies regarding all controlled substance prescriptions. My physician may access this data at any time if there is concern that I may be violating this Controlled Substance Agreement.
- I will notify my physician's office during office hours at least five (5) business days in advance before running out of medication(s) so the appropriate refills can be made.
- I understand that refills **will NOT** be ordered before the scheduled refill date even if my medication(s) runs out. Controlled Substances may be refilled no earlier than 30 days following the most recent prescription has been sent to the pharmacy. When traveling, arrangements must be made in advance of planned departure date as early refills will not be provided.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my physician liable for problems caused by the reasonable discontinuance of the medication(s).
- I recognize that my condition represents a complex problem which may benefit from other therapies (i.e., physical therapy, psychotherapy, alternative medical care, etc.). I also recognize that my active participation in the management of my condition is extremely important. I agree to actively participate in all aspects of the management program recommend by my physician to achieve increased function and improved quality of life.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of other medication(s) prescribed by other doctor(s).
- I must keep all follow-up appointments as recommended by my physician or my treatment and / or medication(s) may be discontinued.

I certify and agree to the following:

- 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 informed consent and controlled substance agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
- I have been given an opportunity to ask questions about my condition, alternative forms of treatment and risks of nontreatment, the medication(s) to be used, the risks and hazards involved, and all other provisions contained in this Controlled Substance Agreement. All of my questions have been answered to my satisfaction and that I have sufficient information to give this informed consent.
- I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.
- I agree to the use of the medication(s) in the treatment of my condition and to the terms of this informed consent and Controlled Substances Agreement.

DATE: ___________________________________ TIME: ____________________________

PATIENT SIGNATURE: ____

PATIENT PRINTED NAME: ____

WITNESS/**PHYSICIAN**: ____

Credit Card Charge Authorization

I understand that full payment is required at the time of service by either cash, check, or credit card. Full payment is also required for missed appointments and cancellations with less than 24 hours prior notice (including weekends).

I also understand that the financial responsibility for services provided is mine, and that I must file for any insurance reimbursement to which I may be entitled because Round Rock Psychiatry will not file insurance claims on my behalf.

I understand that the credit card listed below will be charged for services rendered and for the missed and cancelled appointments with less than a 24-hour notice. If the credit card charge is denied, I will be billed separately for the appointments. Round Rock Psychiatry will not schedule any further appointments until I pay all outstanding balances.

I agree to call and notify the clinic, in advance of my next scheduled appointment, if my address, phone number, or responsible party has changed.

I hereby authorize Round Rock Psychiatry to charge my credit card for services rendered to me or the patient whose name appears below (and for appointments missed or cancelled with less than a 24-hour notice) at current posted rates (see Fee Schedule).

Patient Name (printed)____

Credit Card # _________________________________ Security Code _______ Exp. Date _____________

Name (as printed on card ____

Billing Address (shown on the card statement) ____

City ____ State ________________ Zip Code __________

By signing below, I am authorizing Round Rock Psychiatry to charge my credit card for the professional services as described above. I certify that I am the owner of the credit card listed on this form and can authorize charges to this card.

Cardholder' Signature_____________________________________Date__________________________

Cardholder's Relationship to Patient (if other than self) ____

Email HIPAA Consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the Health Insurance Portability and Accountability Act.
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- Information stored on our computers is encrypted.
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email.
- When we send you an email, or you send us an email, the information that is sent **is not encrypted**. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA.
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of **unencrypted** email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via **unencrypted** email.

I understand the risks of **unencrypted** email and do hereby give permission to Round Rock Psychiatry and Dr. Israel C. Calzada to send me personal health information via unencrypted email.

Signature____ Date ______________________

Email address____

Round Rock Psychiatry
www.roundrockpsychiatry.com
512-550-1715

Telepsychiatry Informed Consent

Telepsychiatry is the delivery of psychiatric services, online, using interactive audio and visual electronic systems where the psychiatrist and the patient are not in the same physical location. Round Rock Psychiatry allows Dr. Calzada to perform telepsychiatry for any appointment, but only through the telemedicine service provider **Doxy.me, LLC**. The interactive electronic systems used by Doxy.me incorporate network and software security protocols to protect the confidentiality of patient information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential telepsychiatry benefits include patient convenience, increased accessibility to psychiatric care, and increased privacy and confidentiality; as you, the patient, would not have to travel to the clinic but would be able to attend appointments from the comfort of your home or office, or any place of your choosing (within the state of Texas) utilizing any desktop or laptop computer, tablet or smartphone.

Potential Telepsychiatry Risks include information being transmitted over the internet, and in some instances may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision-making by Dr. Calzada. Also, delays in psychiatric evaluation and treatment could occur due to deficiencies or failures of the equipment (although the appointment could be concluded over the telephone at no extra charge). Other risks include failure of security protocols resulting in a breach of privacy of the patient's confidential medical information. In rare cases, a lack of access to all the information that might be available during an in-office visit, but that may occur in a telepsychiatry session, could result in the omission of care involving other health problems or possible adverse drug interactions.

If Dr. Calzada decides that the benefits outweigh the risks, he may request telepsychiatry sessions when the patient schedules follow-up appointments. If Dr. Calzada agrees, the patient will be scheduled for a telepsychiatry session, and will be sent an internet link (to http://Doxy.me) via email or telephone with instructions to log into the “waiting room” immediately prior to my scheduled appointment.

Patient Rights ("I" and "My" refers to you the patient): (1) I understand that all laws protecting the privacy and confidentiality of medical information also apply to telepsychiatry. (2) I understand that all the Texas rules and regulations which apply to psychiatry also apply to telepsychiatry. (3) I understand that my psychiatrist has the right to withhold or withdraw his consent for the use of telepsychiatry at any time during the course of my care. (4) I understand that I have the right to withhold or withdraw my consent for the use of telepsychiatry at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment from my psychiatrist.

My Responsibilities: (1) I understand that I must be physically within Texas (including offshore State waters) to be eligible for telepsychiatry, and my psychiatrist can send prescriptions for medications only

to Texas pharmacies or addresses. I will inform my psychiatrist as soon as my session begins of my physical location. (2) I will ensure the proper configuration and functioning of all my electronic equipment **prior to my session** because the computer, tablet, or mobile telephone I use must have working camera and audio input so that my psychiatrist can see and hear me in real time. (3) I will not record any telepsychiatry sessions without prior written consent from Dr. Calzada and I understand that my psychiatrist will not record any of my telepsychiatry sessions without my prior written consent. (4) I will inform my psychiatrist as soon as my session begins if any other person can hear or see any part of our session. (5) If I lose my connection during a session, I will immediately attempt to log back into the http://Doxy.me "waiting room." (6) If the audio I am receiving during a telepsychiatry session is not complete and clear, I will attempt to let my psychiatrist know or connect via telephone to complete the appointment or schedule a new appointment.

Patient Consent to the Use of Telepsychiatry: I have read and understand the information provided above regarding telepsychiatry. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize Dr. Calzada to use telemedicine in the course of my diagnosis and treatment. I agree to hold Round Rock Psychiatry and Dr. Calzada harmless from injuries or omissions that may be related to the limitations, malfunction or technical failure of equipment or system encryption.

______________________________	______________________
Printed name	Date
______________________________	______________________
Signature of patient (or parent, legal guardian, or conservator)	(Relationship to patient)