AUSTIN FAMILY MENTAL HEALTH, P.A.

PATIENT INFORMATION FORM

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

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ - _____ - _____ Sex: ☐Male ☐Female

Best Contact Phone Number: _____ Okay to leave message? ☐Yes ☐No

Email address: _____ Employer/School: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Partner

Name of spouse/partner: _____

Medical Doctor's Name: _____ Phone Number: _____

Have you consulted a Psychiatrist before?

If so, name and address: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

Allergies: _____ List of Current Medications: _____

Medications Continued: _____

Pharmacy name: _____ Pharmacy Address: _____
Phone Number: _____

IF PATIENT IS A MINOR, please provide the following information if different from above:

Parent's / Guardian's Name (s) _____
Parent's/Guardian's Email: _____
Parent's/Guardian's Cell Number: _____Okay to leave message? ☐Yes ☐No

Address: _____ City: _____ Zip: _____

Relationship to Patient: ☐Parent ☐Legal Guardian

CORRESPONDENCE INFORMATION:

Please initial below if you would like to provide authorization to our office to correspond with you via email.

INITIAL _____

INSURANCE INFORMATION:

Insurance Carrier: _____ ID Number: _____ Group Number: _____

Subscriber Information:
Subscribers Name: _____ Phone Number: ( ) _____-_____ Email: _____
Address: _____Social Security: _____ - _____ - ____ DOB: _____

I, _____, authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to Austin Family Mental Health, PA.

INITIAL _____

If you are over the age of 18 and a parent/guardian is responsible for payment, and you authorize us with permission to speak to them about your account, please provide their information below:

Name: _____ Relationship: _____ Phone Number: _____
Address:_____Email:_____

PAYMENT FOR SERVICES: I, _____, understand payment is required at the time care is provided. Payment with cash, checks and credit cards is accepted at the office at the time of your appointment. Your signature on this form notes your agreement to pay **and authorize our office to charge your credit/debit card on file** for all services provided by this office, including but not limited to copays/deductibles, missed appointments, late cancellation fees, telephone consults, prescription fees and non-urgent after hours phone calls. If you wish to use a different card than the one that is on file at the time of service, please provide us with the new card information when you arrive for your appointment. Should you have difficulty paying for services, we are more than happy to discuss payment arrangements.

INITIAL _____

I would like to sign an authorization form so that the following person (s) may speak with you about my care:

Name: _____ Phone: _____ Email: _____

Relationship: _____

HIPAA PRIVACY POLICIES:

Signing below confirms I have read the office's HIPAA & Texas Privacy Policies and have been offered a copy of them. It also notes my agreement that my Private Health Information may be transmitted by phone, fax and email.

Signature: _____ Patient/Guardian Date: _____

Notice of Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA)

Austin Family Mental Health has the responsibility to protect the privacy of your personal and health information as described in this notice. Personal health information includes medical (or psychological) information and individually identifiable information, such as your name, address, telephone or social number. Austin Family Mental Health is required by applicable federal and state laws to maintain the privacy of your personal and health information or "PHI."

Austin Family Mental Health will protect your privacy by, limiting how we may use or disclose your PHI; limiting who may see your PHI; inform you of our legal duties with respect to your PHI; and explain and strictly adhere to our privacy policies. These policies are in effect as of April 14, 2003, and will remain in effect until updated and until you receive notice of any changes. Austin Family Mental Health reserves the right to change these policies and the terms of this notice as allowed by state and federal laws, rules or regulations.

Uses and Disclosures of Clients Personal and Health Information:

Austin Family Mental Health may disclose your PHI to insurance carries in order to receive payment for claims for the services provided to you by Austin Family Mental Health within the limits established by the Texas Medical Board.

Austin Family Mental Health may use your PHI to contact you with information about services provided, appointment reminders, or for collection of co-pays or your account balance (if any).

Austin Family Mental Health may use your PHI to the extent necessary to avert a serious and imminent threat to your health or safety of others. Austin Family Mental Health may disclose this information to the proper authorities, if we reasonably believe that you are a possible victim of child abuse, child neglect.

Austin Family Mental Health must disclose your PHI when we are required to do so by the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with privacy laws.

Austin Family Mental Health may disclose your PHI in response to a court order or subpoena, although every effort will be made to obtain your consent for the releases of any personal or health information, as required by confidentiality regulations as set by the Texas Medical Board.

Austin Family Mental Health may disclose your PHI to law enforcement officials or personnel of a correctional institution if you are in lawful custody while receiving treatment.

Your Rights:

You have the right to review or obtain copies of your personal and health information, subject to the limitations of the TMB. Your request must be in writing and you may be charged a fee for copying of the record.

You have the right to request and receive a list of instances in which Austin Family Mental Health disclosed your PHI for purposes other than treatment and claims processing.

You have the right to request that Austin Family Mental Health place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by the agreement. You also have the right to terminate or amend previously requested restrictions. Requests for additional restrictions or requests for termination of requested restrictions must be in writing.

You have the right to request that Austin Family Mental Health communicate with you in confidence about your PHI by alternative means. You must specify how we may contact you in writing, if you do not wish to be telephoned at your primary or secondary listed telephone numbers.

You have the right to request and amendment of your PHI. The request must be in writing and include the information to be amended. If Austin Family Mental Health agrees to the amendment, we will make a reasonable effort to include the changes in any future disclosures of information.

You have the right to receive a copy of this notice in written form.

You have the right to file a complaint if you believe Austin Family Mental Health has violated your privacy rights or you disagree with a decision we made about access to your PHI. A complaint may be made to Austin Family Mental Health or you may also submit a written complaint to The U.S. Department of Health & Human Services Office of Civil Rights. Austin Family Mental Health supports your right to file a complaint and will assist you by providing address information for the HHS, and will not retaliate in any way if you choose to file a complaint with us or HHS.

Written Authorization to Use or Disclose Your PHI:

Austin Family Mental Health will request written authorization from you to use your PHI or to disclose it to anyone for any purpose or situation not included in this document. You may revoke this authorization in writing at any time. Your revocations will not affect any use or disclosure permitted by your authorization while it was in effect. We will not disclose your PHI for any reason except those described in this notice without your written consent.

Acknowledgement of This Notice of Privacy Regarding Your PHI:

Acknowledgement of this notice of privacy will be made part of your medical record with Austin Family Mental Health. Please sign and date below. You may request a copy of this notice at any time.

_____
Patient/Client Name

_____
Relationship to Patient:

_____
Signature of Patient/Client or Legal Guardian (if minor)

_____
Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Office Policies and Procedures

Welcome to our office. We appreciate the opportunity to serve you. Please read the following information carefully. If you have any questions or concerns, please do not hesitate to ask a member of our staff or your provider. The following policies are subject to change without notice.

Appointments:

New Patients: The $100.00 deposit that you paid to secure your new patient appointment will be forfeited if one of the following occurs:

- If you no show to your scheduled appointment
- If you fail to provide us with 24-business hours' notice of cancellation
- If you are more than 10-minutes late to your appointment which results in us having to reschedule you to another day

1. In consideration of all patients, individuals who arrive 10-minutes late may need to reschedule
2. Appointments must be cancelled 24-business hours in advance to avoid a missed appointment fee. The fees are as follows: **Nurse practitioners:** Cancellation & No-Show Fee: $150.00 **Psychiatrist:** Cancellation & No-Show Fee: $175.00
3. Missed appointment fees must be paid *prior to* the next appointment. Patients who have missed more than one appointment may be required to put a credit card on file in the event another appointment is missed
4. 3 missed or late cancellations will result in the discontinuation of our professional relationship
5. Our EMR system will send *courtesy* appointment reminders 1-2 days prior to your scheduled appointment; however, it is ultimately the client's responsibility to attend scheduled follow-ups
6. We encourage clients to make or move up an appointment when a complaint or a problem occurs regarding their mental health and/or medication changes. Phone calls and emails to your provider may be assessed a fee

Initial _____

Billing and Payment:

We believe in the importance of providing access to care to the greater Austin area and choose to accept insurance. We have put policies in place to ensure we can maintain an insurance-based practice and serve the community.

- Payment (i.e. co-payment, co-insurance, deductibles, fee-for-service, and any balance) is due at the time of service. If you are unable to make payment at the time of service, you may be asked to reschedule your appointment.

- The information provided to us by your insurance company is not always accurate and we encourage you to be informed as to what benefits *your insurance covers* and what your patient responsibility is.

- Our office only submits claims to insurance companies for which we are "in-network." If you wish to file out-of-network with your insurance company, please inform our staff so they can provide you with an itemized statement.

- It is important to communicate with our office if you have a change of insurance as most insurance companies have a *90-day filing deadline*. Failure to provide us with accurate insurance information may result in *your* responsibility of payment in *full* for services provided.

- While payment is due at the time of service, often unpaid balances accrue. It is our policy that as soon as an unpaid balance reaches $200.00 no further services will be provided until the balance has either been cleared or brought below $200.00. *Please note that patients are welcome to set-up a payment plan by authorizing a monthly debit to a credit card to pay their balance. If a patient's payment agreement is declined more than once, the contract is considered null and void and services are discontinued. Patients will be provided a one-month refill of non-controlled medications to allow time to find a new provider. It will be the decision of the provider if they wish to begin the working relationship again once the balance is paid.

- Patients with existing payment plans are not allowed to accrue additional balances and are unable to add to an existing payment plan.

- Accounts with no payment activity for 90 days will be turned over to a collection agency. It is our policy that once an account is turned over, services are discontinued.

Initial _____

Medication Refills:

Prior to calling our clinic, we ask all patients to either have their pharmacy fax us a refill request and/or email their request to: frontdesk@austinfamilymentalhealth.com Upon request, we will authorize refills when appropriate. Please allow 2 business days to process your request. Patients are to submit requests when they have at least 2-3 days of medications at hand. If you have not heard from our staff in 2 business days after submitting your request, please call us. We utilize an electronic prescribing system and do not provide paper prescriptions.

- Medications taken more than prescribed will be denied an early refill. If you would like to discuss a change in medication, please call the office to setup an appointment.
- Texas law requires patients to be under medical supervision when taking controlled medication. Patients on controlled medications will be required to follow-up with their provider every 90 days.
- Prescriptions requested to be filled the same day will be assessed a $20.00 fee.
- Our office will not refill medications outside of normal business hours.
- There is a $12.00 fee to write controlled medications between appointments. Alternatively, you may come in monthly to obtain your medication.
- All schedule II medications (Vyvanse, Adderall, etc.) must be filled within 21 days or they will expire.
- Stolen/lost controlled medications will not be refilled early and patients will have to wait until they are eligible for another refill.

It is important to note that stimulants are not lifesaving medications and running out does not constitute a medical emergency. Early refills are not permitted.

Initial _____

Prior-Authorizations:

If *your benefit company denies your medication* and requires your provider to provide clinical documentation to approve a medication, you will be assessed a $25.00 fee. This is a very time-consuming task for the provider and staff. We highly suggest you speak with your benefit company if they continue to deny your medication. Please allow 72 business hours to process such requests. If the medication is generic, and affordable, you may want to pay out-of-pocket.

Initial _____

Confidentiality:

Our office understands the need to keep your information confidential, and we will act in good faith to maintain your matters private. Please use caution in leaving us home/work/cell numbers and/or an email address to contact you. Please ensure you provided us with updated information to ensure your confidentiality is not jeopardized.

Our office requires a signed Release of Information to speak with family member, providers, disability companies, or anyone to whom you would like to have access to your information.

We appreciate your cooperation with our Office Policies outlined above.

I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Printed Name: _____

Signature: _____ Date: _____