NEW PATIENT PAPERWORK: ADULT

To best serve your medical needs, we ask that you complete the following packet in full before your appointment. We ask that you print out the packet as it is given to you and in black ink. When filling out the packet, please use black or blue ink. If you are unable to comply with these, please arrive 40-45 minutes prior to your appointment so that you can complete your paperwork in a timely manner. We appreciate your cooperation with us.

REGARDING INSURANCE PLANS

You can be helpful in preserving our ability to provide services to you under your insurance plan by making certain that you track the timely payment of your claim. If you do not receive an Explanation of Benefits (EOB) from your insurance company within 30 days from the date of your appointment, you should call them to check on the status of your claim. If you receive an EOB, but it shows that no payment was made to us, you need to call your insurance company. Unpaid balances beyond 45 days will, by necessity, be charged to your credit card. Hopefully, your efforts and ours will meet with success.

Thank you.

NEW PATIENT INFORMATION

PATIENT INFORMATION

Patient's Name: _____
(First) (Middle) (Last)
Date of Birth: _____ SSN: _____ Marital Status: _____
Street Address: _____
City: _____ State: _____ Zip Code_____
Email Address: _____
Primary Phone: _____ Alternate Phone_____
Name of parent or legal guardian (for minor under age 18): _____

INSURED PARTY INFORMATION (if different than above)

Primary Policy Holder Name: _____
(First) (Middle) (Last)
Relationship to Patient: _____
Street Address: _____
_____
City: _____ State: _____ Zip Code_____
Insured Party Date of Birth: _____ Last Four of SSN: _____ Driver's License#_____
Insurance Company Name: _____ ID or MEMBER #: _____
Member Services Phone #: _____
Email Address: _____
Employer: _____
Occupation: _____

EMERGENCY CONTACT INFORMATION

In case of emergency, call: _____
Relationship to patient: _____ Primary Phone: _____
Alternate Phone: _____ Email: _____

Signature: _____ Date: _____

COORDINATION OF CARE WITH PRIMARY CARE PROVIDER

Communication of your treatment plan with your Primary Care Provider (PCP) is important to your overall health care. Please sign the necessary authorization to release this information to your primary care physician.

Name of Primary Care Physician: _____

Address: _____

Phone Number: _____Fax Number: _____

I, _____, authorize Texas Behavioral Health Systems, PLLC to share with my primary care provider named above, any medical information regarding the following patient.

Patient Name: _____
This authorization is effective until revoked by me in writing.

_____ _____ / _____/ _____

Authorizing Signature Date

_____

Printed Name

****

(Remainder to be completed by TBHS Staff) [ ] Mailed or Faxed to PCP [ ] Logged into Database

To Primary Care Physician,

Your patient _____ DOB: ____ / ____ /____

was seen by one of our treating providers on ____ / ____ /____.

Treating provider: [ ] Karah Brashier, DNP, APRN, PMHNP-C [ ] Matthew Vickers, APRN, PMHNP-C
[ ] Dasha Joseph, APRN, PMHNP-C [ ] Sophie Krchmar, APRN,PMHNP-C [ ] Christina Zazay, APRN, PMHNP-C
[ ] Collaborating Physician: Dr. Paul M. Hamilton, M.D.

Treatment plan/ Prescribed medication(s)_____
_____
_____
_____
_____

Purpose: _____
Referral to Therapy: _____ Other: _____
Recommended Lab Monitoring: _____

****PLEASE SEND MOST RECENT VISIT NOTE AND LABWORK TO OUR OFFICE VIA FAX AT (214) 227-1333**

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete this form if you are seeing a therapist or counselor or would like to include other parties in your consent.

I, _____, authorize Texas Behavioral Health Systems PLLC providers and/or designated staff to disclose and provide information, including copies of specified protected health information regarding _____ (patient name)

to the following party (name of persons or entities to whom you would like information shared).

[ ] Therapist or Counselor _____

[ ] Other Party _____

Address: _____

Phone Number: _____ Fax Number: _____

Protected health information I am authorizing for disclosure is: (Check all that apply)

___Psychiatric Evaluation
___Progress notes
___Medication Records
___Treatment Plan or Summaries
___Hospital Records Created by providers at TBHS
___Mental Health Records
___Substance Abuse Records
___Lab Tests or Studies
___ Billing Records
___ Other (Specify)_____

Purpose of Disclosure:

___Request of authorized individual or patient
___Continuation of care by another clinician
___To assist in employment accommodations
___To assist in educational accommodations
___In support of application for insurance
___Security investigation for employment
___Insurance review of my claim for services
___For review in legal matter

This authorization will be in force and effect until revoked in writing by me via Certified Mail to **Texas Behavioral Health Systems, PLLC PO Box 2386 Frisco, Texas 75034**. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient who may not be bound to the same confidentiality standards as my provider, and therefore, such disclosed information may no longer be protected by federal or state law. I hold Texas Behavioral Health systems providers and staff harmless for any adverse consequence derived directly or indirectly from the authorized release of protected health information.

_____ _____
Patient Name Date

_____ _____
Printed Name (if different than above) Signature of Patient or Authorized individual

Notice to Recipient: This information is protected by Federal (42CFR, Part 2) and State laws regarding confidentiality. These statutes prohibit you from disclosing this information to anyone else. A general authorization is not sufficient regarding mental health and / or substance abuse information.

INITIAL PSYCHIATRIC ASSESSMENT

THIS SECTION TO BE COMPLETE BY PATIENT OR PARENT (IF PATIENT IS A MINOR)

_____ _____ _____/_____/_____
PATIENT NAME (PRINT) **AGE** **TODAY'S DATE**

_____ _____
PERSON COMPLETING THIS FORM (PRINT) **RELATIONSHIP TO PATIENT**

_____
THERAPIST OR COUNSELOR'S NAME, ADDRESS, PHONE NUMBER

REASON FOR EVALUATION: (CHECK ALL THAT APPLY)

____ANXIETY	____AGITATION	____RELATIONSHIP PROBLEMS
____PANIC	____AGGRESSION/VIOLENCE	____BIZZARE THOUGHTS
____DEPRESSION	____IMPULSIVITY	____CONCENTRATION/FOCUS
____MOOD SWINGS	____BEHAVIORAL PROBLEM	____TASK COMPLETION
____SUICIDAL THOUGHTS	____SCHOOL PROBLEMS	____SLEEP PROBLEM
____SUICIDE ATTEMPT	____UNUSUAL BEHAVIOR	____DRUG/ALCOHOL USE

BRIEFLY DESCRIBE PROBLEM: _____

_____

_____

_____

_____

PREVIOUS TREATMENT? _____ WITH WHO? _____

EVER HOSPITALIZED? _____ HOW MANY TIMES? _____ WHEN? _____

WHERE? _____

MEDICATIONS FOR MENTAL HEALTH TRIED IN THE PAST? _____(YES) _____(NO)

NAME OF PAST MEDICATION(S), DOSAGE(S), RESPONSE TO EACH _____

_____

_____

_____

CURRENT MEDICATIONS (Name and dosage. Please include any herbals or supplements

SUBSTANCE USE? (List any substances used, past or present, and last use) _____

_____

_____

HISTORY OF IV DRUG USE? _____

Family History: Any Blood Relatives with the following (Check all that apply):

☐ Alcoholism	☐ Depression	☐ Heart Attack	☐ Parkinson's Disease
☐ Alzheimer's Disease or Dementia	☐ Diabetes	☐ Heart Problems	☐ Schizophrenia
☐ Autoimmune Disorders	☐ Drug Use	☐ High Cholesterol	☐ Suicide
☐ Bipolar Disorder	☐ Genetic Disorders	☐ High Blood Pressure	☐ Sudden, Unexplained Death
☐ Cancer: Type_____	☐ Hallucinations	☐ Liver Problems	☐ Thyroid Problems

LIVING SITUATION: (WHO LIVES AT HOME?) _____

_____

_____

EDUCATION:
CURRENT GRADE LEVEL (MINORS) _____
EDUCATION COMPLETED (ADULTS) ____ HIGH SCHOOL ____ GED ____ SOME COLLEGE ____ COLLEGE GRADUATE ____ POST GRADUATE DEGREE
ACADEMIC PERFORMANCE ____ BELOW AVERAGE ____ AVERAGE ____ ABOVE AVERAGE

CURRENT OCCUPATION/EMPLOYMENT _____

_____

Medical and Surgical History Questionnaire

Please indicate if you have or have ever had one of the following conditions:

Medication Allergies: _____ HEIGHT: _____ WEIGHT _____ (lbs.)

☐ Alcoholism	☐ Fainting Spells	☐ Mania
☐ Alzheimer's Disease	☐ Fibromyalgia	☐ Memory Problems
☐ Anxiety	☐ Gallbladder Removal	☐ Menstrual Problems
☐ Appendix removal	☐ Gender Affirming Surgery	☐ Migraines
☐ Arthritis	☐ Genetic Disorders	☐ Multiple Sclerosis
☐ Asthma	☐ Glaucoma	☐ Muscle Disease
☐ Autoimmune Disorder	☐ Hallucinations	☐ Numbness or tingling in limbs
☐ Bleeding Disorder	☐ Head Injury/Concussion	☐ Osteoporosis
☐ Blood Clots	☐ Hearing Problems	☐ Palpitations
☐ Brain surgery	☐ Heart Attack	☐ Parkinson's Disease
☐ Breast surgery	☐ Heart murmur/arrhythmia	☐ Repetitive Movements (tics, etc…)
☐ Cancer	☐ Heart Surgery	☐ Rheumatoid Arthritis
Type_____	☐ Hepatitis	☐ Seizures
☐ Cardiac arrest	☐ HIV/AIDS	☐ Sleep Apnea
☐ Chronic Back Pain	☐ High cholesterol	Using CPAP? Y or N
☐ Chronic Constipation	☐ High blood pressure	☐ Spine surgery
☐ Chronic Diarrhea	☐ Gastritis/Ulcers	☐ Stroke
☐ Chronic Pain	☐ Gastroesophageal reflux disease (GERD)	☐ Thyroid disease
☐ Colon surgery	☐ Hysterectomy	☐ Thyroid surgery
☐ Congestive heart failure	☐ Joint surgery or replacement----	☐ Tubal ligation
☐ Depression	☐ Kidney disease	☐ Tuberculosis
☐ Diabetes Type I	☐ Kidney stones	☐ Vascular surgery
☐ Diabetes Type II	☐ Liver Disease	☐ Weight reduction surgery
☐ Drug Use/Recreational Drug Use	☐ Lupus	
☐ Emphysema/COPD	☐ Lung surgery	

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Information Regarding Controlled Substances: The purpose of this information is to create an understanding regarding controlled substances. **Please initial each line to indicate understanding:**

____ The goal of treatment is to reduce symptoms to a bearable level to improve the quality of my life. I understand that in many cases, symptoms may not be completely eliminated. Increasing doses may not always help, and in some cases may cause further complications.

_____ Use of illegal substances, alcohol and combinations of other mood-altering drugs, including prescription medications, can lead to dangerous side effects, including respiratory depression and death.

_____ Prolonged use of controlled medications may be associated with serious health risks that will be discussed by my provider, including dependence on or addiction to these medications.

_____ The risk of abruptly stopping a controlled medication may cause complications. If I need to stop this medication, I must do under the advice of my provider.

_____ Stimulant medications, such as Adderall, Ritalin, Vyvanse, etc… are known to have an effect on the cardiovascular system. Your provider may periodically monitor your vital signs. If your provider has concerns about your blood pressure or pulse, clearance by a primary care provider or cardiology may be required.

_____ It is not advisable to combine stimulant medications with some medications, caffeine or energy drinks

_____ Stimulants can cause other side effects such as heart palpitations, chest pain, blurred vision, syncope (fainting), activation of mania or psychosis, insomnia, increasing agitation/anxiety, seizure activity, weight loss, intolerable nausea or headache. Please notify your provider immediately if you experience any of these side effects or proceed to the nearest hospital emergency room for unrelieved chest pain.

_____ I am responsible for my medications. I will not share, sell, or trade my medication. I will not take anyone else's medication. Federal, state and local laws prohibit these actions.

_____ I will not increase my medication dose unless approved by the prescribing provider.

_____ I will keep my medications in a secure place. My medicine may not be replaced if it is lost, stolen or used sooner than prescribed.

_____ My provider may order a blood, urine, or saliva sample to test for medications or drug use.

_____ I must use extreme caution regarding driving or operating heavy machinery when taking these medications as side effects can include drowsiness or a change in mental abilities, thereby making it unsafe to do so.

_____ I agree that drinking any amount of alcohol while I am receiving DEA controlled medication, especially benzodiazepines, could suppress my breathing, especially while sleeping, and result in death due to respiratory failure.

_____ I understand that if I become pregnant while taking these medications, my child may be born dependent on the medication and other health risks to my child may exist. It is not advisable to take controlled substances while pregnant. I will contact my provider immediately if I become pregnant.

_____ If I see another provider who gives me a controlled substance medicine (for example, a dentist, doctor from an Emergency Room or hospital, etc.), I must notify your office immediately.

_____ I understand that my medications may be changed or stopped at any point in my treatment at my provider's discretion.

_____ _____

Signature Date

The "Off-Label" Use of Medication

There are times we prescribe medications which are not labeled specifically for usage in a particular condition. This is because the U.S. Food and Drug Administration (FDA) indications for any given drug is based on their review and acceptance of studies which have been submitted to them for usage in a specific diagnosis, rather than symptoms. Medications treat symptoms, not diagnoses. There are times when a medication is found to be useful for one symptom or disorder, but clinical experience reveals that it is also useful in other areas. When this occurs, pharmaceutical companies occasionally conduct new medication trials and seek additional FDA approval. This pursuit of "indication for use" from the FDA is a business decision that many pharmaceutical companies decide **not** to make because of the extremely high cost of medication research and testing and the fact that the medication has already received approval for prescribing. Most pharmaceutical companies decide to rely upon doctors learning of these additional uses through articles published in medical journals, professional educational forums, and collegial networking. The usage of medications without FDA indication for a certain condition is referred to as "off label" use.

There are special circumstances in regard to children. Most of all the medications that child psychiatrists, pediatric neurologists, and pediatricians use are used "off label." Considering the complications of testing medication on children (a child cannot sign a waiver stating that he/she understands the risks of being involved in medication research), there are very few medications that are "approved" by the FDA for children. An example of an "off label" use of medication with which you might be acquainted would be amoxicillin. Amoxicillin was widely used with adults and its success in treating infection led to its almost immediate embrace by pediatricians. Because it was already being used with children, the manufacturer never sought an approved indication and to this day, amoxicillin is not "approved" by the FDA for use in children, although its use is nearly universal.

It is important for you to understand that the medication we recommend and prescribe have been shown to be helpful in the hands of many providers. We want you to be informed of the possible benefits and side effects of these medications and encourage you to read all you can and ask questions that you have. We are committed to pursuing a plan of action which leads to the lowest dosage of medication and the smallest number of medications used, consistent with optimal level of wellness. Our goal for the medication we prescribe is to treat and reverse as many symptoms as possible while pursuing additional non-medication strategies. Counseling and lifestyle changes can further add to the recovery from the presenting symptoms in the short-term. This will also enable the medication itself to work more effectively and may, in the long run, possibly negate the need for some or all of the medications originally prescribed.

Please feel free to express any concerns or questions you may have during your visit. We endeavor to provide you all the information we can in order to help you make informed decisions concerning you or your child's care.

CONSENT FOR TELEHEALTH

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up, and/or education. The electronic systems used for telehealth will incorporate network and software security protocols to protect patient privacy and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits: Telehealth offers improved access to medical care by enabling patients to remain in their home or secure location while a healthcare provider at an alternate location provides non-emergency medical evaluation, non-crisis care, treatment recommendations, medication management, and individual or family psychotherapy sessions.

Potential Risks: As with any behavioral health evaluation, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the healthcare provider and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions, or other judgment errors.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.

4. I understand that telehealth may involve electronic communication of my personal medical information to other medical providers who may be located in other areas.

5. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.

6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Consent for Treatment/Financial Responsibility/Authorization to Release Medical Information

I, _____, am fully authorized to consent to treatment to be rendered to me, my child,
(Patient or responsible party—Please print)
or other person designated below, and, in so doing, agree to be responsible for the payment of professional fees. **Such fees may include, but are not limited to, patient copays, co-insurance, deductibles, non-insured services (such as prescription renewals outside of your appointment time, pharmacy authorizations, telephone calls, document preparation, hospital admission coordination, etc.), or services deemed by my insurance company or its agents as medically unnecessary or not covered. In the event that my insurance coverage cannot be ve3rified prior to service delivery, I agree that I will be responsible for payment in full. I further agree that I am responsible for payment of the full billed amount of charges not paid by my insurance company or its agent within 45 days from the date of their receipt of a claim. (In accordance with The Texas Insurance Coe and Department Rules, Articles 3.70-3C, Section 3A and 20 A.18B ad in the Texas Administrative Code Sections 21.2801-21.815). In addition, a surcharge of $2 per day will be added to any unpaid balance beyond sixty (60) days. Unpaid insurance claims and any associated charges are considered as supplemental charges. A fee of $60.00 is charged for missed appointments, unless canceled 24 hours in advance. The office does not file out of network claims but will provide a statement for you to file. Full payment for those covered by a non-network plan is due at the time of service.**

I authorize Texas Behavioral Health Systems, PLLC, or those acting in its behalf, to provide information regarding my medical, psychiatric, or substance abuse treatment to my insurance company or its agents for the purpose of determining benefit eligibility, for certification of care, or for claims processing purposes. This authorization is valid until revoked in writing by me or by my legal guardian. By signing this document, I represent to Texas Behavioral Health Systems, PLLC and its employees that I have in force, and am entitled to, the benefits of any applicable health plan which I have presented. I hold Texas Behavioral Health Systems, PLLC and its employe3es harmless for any damages resultant from denial of payment, lack of certification, lack of payment for medically recommended treatment, or failure on the part of my insurance company or its agents to maintain confidentiality regarding my condition. I assign my insurance benefits to Texas Behavioral Health Systems, PLLC.

_____ _____
Patient (Recipient of Care)—Please Print Date

_____ _____
Signature Date

_____ _____
Responsible Party (if other than patient)—Please Print Date

Signature of Responsible Party _____

We require a credit or debit card for services not covered by insurance:

Unpaid balances for services rendered **including those listed above,** may be charged to the following Credit or Debit card [ ] MC [ ] VISA [ ] DISCOVER

Card No. _____ Exp Date _____

Cardholder Name _____ (Please Print)

Cardholder Signature _____

HEALTH INFORMATION PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

UNDERSTAND YOUR HEALTH RECORD INFORMATION

This notice describes the practice of Texas Behavioral Health Systems, PLLC (hereinafter "TBHS") and that of its licensed providers with respect to your protected health information created while you are a patient at TBHS. TBHS licensed providers and personnel authorized to have access to your medical chart are subject to this notice. In addition, we create a record of the care and services you receive at TBHS. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at TBHS. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of TBHS, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, healthcare operations and as to disclosures permitted to persons, including family members involved with your care as provided by law. However, we are not required by law to agree to a requested restriction.
- Obtain a paper copy of this notice of information practices.
- Inspect and request a copy of your health record as provided by law.
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record.
- Obtain an accounting of disclosures of your health information as provided by law.
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.
- Revoke your authorization disclose health information except to the extent that action has already be taken.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of this notice to the Practice Administrator at TBHS.

Our Responsibilities:

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures.
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change, we are not required to notify you, but we will have the revised notice available at your request.
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law

The following categories describe different ways that we use and disclose medication information. For each category, we will explain what we mean & give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment. For example: We may disclose medical information about you to your primary care physician or subsequent health care providers with copies of various reports to assist in treating you once you are discharged from TBHS.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that may identify you, as well as your diagnosis.

Business Associates: There are some services provided in our organization through agreements with business associates. Examples including: copying services, accounting services, computer services, etc. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may leave appointment reminders on your answering machine or voicemail at home or work, or with a person answering the telephone.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law. For example: You may apply for Disability Insurance Benefits or Life Insurance. Your insurance carrier may request medical information to review your application.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and/or law enforcement purposes. We will disclose medical information about you when required or allowed to do so by federal, state, or local law.

I acknowledge that I have reviewed and accept the TBHS policy regarding Health Information Practices.

Notice Concerning Complaints

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas Board of Nursing Attention: Enforcement 333 Guadalupe St, Suite 3-460 Austin, Texas 78701 1-800-201-9353	Texas State Board of Medical Examiners Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, TX 78768-2018 1-800-201-9353

Aviso Sobre Quejas

Se pueden presenter quejas acerca de medicos, así Tambien como de otras personas authorizadas y registradas por la Junta de Examinadores Médicos del Estado de Texas (Texas State Board of Medical Examiners), incluyendo a ayudantes medicos y acupucturists, para su investigación, en la siguiente dirección:

Texas Board of Nursing Attention: Enforcement 333 Guadalupe St, Suite 3-460 Austin, Texas 78701 Se puede obener ayuda para presntar una queja llamando al siguiente: Telefónico: 1-800-201-9353	Texas State Board of Medical Examiners Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, TX 78768-2018 Se puede obener ayuda para presntar una queja llamando al siguiente: Telefónico: 1-800-821-3205

Consent to Treatment

I, _____ Date of Birth ___/_____/_____, as the person receiving treatment, grant consent and permission to licensed providers and associated clinicians (dba, Texas Behavioral Health Systems, PLLC) for psychiatric evaluation and treatment.

Acknowledgement of Receipt and Review of

- **Office Policies**
- **Consent for Telehealth**
- **The "Off-Label Use" of Medications**
- **Health Information Practices**
- **Notice Concerning Complaints**

By signing below I am agreeing that I have read, understand and agree to the items contained in this document.

_____
Patient Name (Print)

_____
Name of parent/legal guardian (Print)

_____
Patient or Parent/Guardian Signature Date

_____
Relationship to patient

Attention Medicare Patients:

Texas Behavioral Health Systems, PLLC and associated providers do not accept assignments from Medicare and do not file Medicare claims.

You may enter into a "Private Contract" with Texas Behavioral Health Systems, PLLC and associated providers or you may decide to fine a new psychiatrist who accepts Medicare assignment. If you decide to enter into a Private Contract, you (the beneficiary) or your legal representative:

- Accepts full responsibility for payment of the charges for all services furnished by the physician/practitioner.
- Understand that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner.
- Agree not to submit a claim to Medicare or to ask the physician/practitioner to submit the claim to Medicare.
- Understand that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
- Enters into the contract with the knowledge that you have the right to obtain Medicare covered items and services from physicians and practitioners who have not opted out of Medicare and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.
- Understands that Medigap plans do not make payments for items and services not paid by Medicare and that other supplemental plans may elect not to make payments for items and services not paid by Medicare.
- Acknowledge that a copy of this Private Contract was given to beneficiary prior to services being rendered.
- Expected effective date of the opt out period is July 1, 2007 and must be renewed every two years.

If you decide to find a new psychiatrist who accepts assignment from Medicare, you may call (800) 633-4227 or go to http://www.trailblazerhealth.com/tools/MedPard.asp? To find a list of participating psychiatrists.

_____ _____

Medicare Beneficiary/Legal Representative Date

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	☐	☐	☐	☐
Feeling hot	☐	☐	☐	☐
Wobbliness in legs	☐	☐	☐	☐
Unable to relax	☐	☐	☐	☐
Fear of worst happening	☐	☐	☐	☐
Dizzy or lightheaded	☐	☐	☐	☐
Heart pounding/racing	☐	☐	☐	☐
Unsteady	☐	☐	☐	☐
Terrified or afraid	☐	☐	☐	☐
Nervous	☐	☐	☐	☐
Feeling of choking	☐	☐	☐	☐
Hands trembling	☐	☐	☐	☐
Shaky / unsteady	☐	☐	☐	☐
Fear of losing control	☐	☐	☐	☐
Difficulty in breathing	☐	☐	☐	☐
Fear of dying	☐	☐	☐	☐
Scared	☐	☐	☐	☐
Indigestion	☐	☐	☐	☐
Faint / lightheaded	☐	☐	☐	☐
Face flushed	☐	☐	☐	☐
Hot/cold sweats	☐	☐	☐	☐

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

Simple Screening Instrument for AOD Abuse
Self-Administered Form

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

During the last 6 months…

1. Have you used alcohol or other drugs? (Such as wine, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)
   ___ Yes ___ No

2. Have you felt that you use too much alcohol or other drugs?
   ___ Yes ___ No

3. Have you tried to cut down or quit drinking or using alcohol or other drugs?
   ___ Yes ___ No

4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)
   ___ Yes ___ No

5. Have you had any health problems? For example, have you:
   ___ Had blackouts or other periods of memory loss?
   ___ Injured your head after drinking or using drugs?
   ___ Had convulsions, delirium tremens ("DTs")
   ___ Had hepatitis or other liver problems?
   ___ Felt sick, shaky, or depressed when you stopped?
   ___ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   ___ Been injured after drinking or using?
   ___ Used needles to shoot drugs?

6. Has drinking or other drug use caused problems between you and your family or friends?
   ___ Yes ___ No

7. Has your drinking or other drug use caused problems at school or at work?
   ___ Yes ___ No

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)
   ___ Yes ___ No

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?
   ___ Yes ___ No

10. Are you needing to drink or use drugs more and more to get the effect you want?
    ___ Yes ___ No

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?
___ Yes ___ No

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break law, sell things that are important to you, or have unprotected sex with someone?
___ Yes ___ No

13. Do you feel bad or guilty about your drinking or drug use?
___ Yes ___ No

The next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem?
___ Yes ___ No

15. Have any of your family members ever had a drinking or drug problem?
___ Yes ___ No

16. Do you feel that you have a drinking or drug problem now?
___ Yes ___ No

Thanks for filling out this questionnaire.

Note: Stop here, this next section is for clinic staff only.

Scoring for the AOD Abuse Screening Instrument

Name/ID No:_____ Date:_____
Place/Location:_____

Items 1 and 15 are not scored. The following items are scored as 1 (yes) or 0 (no):

___ 2	___ 7	___ 12
___ 3	___ 8	___ 13
___ 4	___ 9	___ 14
___ 5 (any items listed)	___ 10	___ 16
___ 6	___ 11	

Total score: ___ Score range: 0-14

Preliminary interpretation of responses:

Score	Degree of Risk for AOD Abuse
0-1	None to low
0-2	Minimal
≥4	Moderate to high: possible need for further assessment

Center for Neurologic Study-Lability Scale (CNS-LS) for pseudobulbar affect (PBA)

Patient's name:

Date:

Using the scale below, please write the number that describes the degree to which each item applies to you DURING THE PAST WEEK. Write only 1 number for each item.

Applies never	Applies rarely	Applies occasionally	Applies frequently	Applies most of the time
1	2	3	4	5

1. There are times when I feel fine 1 minute, and then I'll become tearful the next over something small or for no reason at all.	
2. Others have told me that I seem to become amused very easily of that I seem to become amused about things that really aren't funny.	
3. I find myself crying very easily	
4. I find that even when I try to control my laughter, I am often unable to do so.	
5. There are times when I won't be thinking of anything happy or funny at all, but then I'll suddenly be overcome by funny or happy thoughts.	
6. I find that even when I try to control my crying, I am often unable to do so.	
7. I find that I am easily overcome by laughter.	

Total Score: