NEW PATIENT PAPERWORK: CHILD/ADOLESCENT

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

____

____

____

7707 San Jacinto Place, Suite 300, Plano, TX 75024 (214) 227-1300 Fax: (214) 227-1333

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

CONSENT TO EVALUATE and/or TREAT MINOR
(Must be completed in regard to anyone under 18 years of age)

Note: Stepparent may not grant permission to evaluate or treat.

In situations of divorce, a copy of your divorce decree section pertaining to custody and consent to medical care must be provided. If you are not the parent, but are legal guardian, you must provide court documents establishing guardianship.

I, ____, as the

( ) Parent

( ) Custodial Parent (in situations of divorce)

( ) Legal Guardian

attest to have legal authority to grant consent and permission to licensed providers and associated clinicians (dba, Texas Behavioral Health Systems, PLLC) for psychiatric evaluation and treatment of:

____ ____/____/_______

(Print Name of Minor) Date of Birth

My name is:

____

(Print)

____

(Signature Parent or Guardian)

Date: ______/______/______

7707 San Jacinto Place, Suite 300, Plano, TX 75024 (214) 227-1300 Fax: (214) 227-1333

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

	YES	NO
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?	❍	❍

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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

Item	
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:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, 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 <u>any</u> problems, how <u>difficult</u> 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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ____________ Child's Name: ______________________________ Date of Birth: ____________

Parent's Name: ______________________________ Parent's Phone Number: ______________________________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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NICHQ
National Institute for Children's Health Quality

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ____________ Child's Name: ____ Date of Birth: ______________

Parent's Name: ____ Parent's Phone Number: __________________________

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ____________

Total number of questions scored 2 or 3 in questions 10–18: ____________

Total Symptom Score for questions 1–18: ____________

Total number of questions scored 2 or 3 in questions 19–26: ____________

Total number of questions scored 2 or 3 in questions 27–40: ____________

Total number of questions scored 2 or 3 in questions 41–47: ____________

Total number of questions scored 4 or 5 in questions 48–55: ____________

Average Performance Score: ____________

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