PATIENT CONTACT INFORMATION

Today's Date _____ Patient's Name _____

DOB _____ Age _____ Gender _____ SSN _____

CONTACT INFORMATION

Address _____

City _____ State _____ Zip _____

Preferred Phone No. _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

May we leave a detailed message? ☐ Yes ☐ No Patient/Guardian Initials _____

Secondary Phone No. _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

May we leave a detailed message? ☐ Yes ☐ No Patient/Guardian Initials _____

Email Address _____

May we communicate with you via email? ☐ Yes ☐ No

Be advised that e-mail is not a secure method of communication.

Emergency Contact Name _____ Phone No. _____

Emergency Contact Relationship: _____

PARENT / LEGAL GUARDIAN INFORMATION If patient is a minor.

Legal Guardian(s) (if applicable) _____

Preferred Phone No. _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

Secondary Phone No. _____ ☐ Home ☐ Cell ☐ Work ☐ Other _____

Email Address _____

Guardianship: If the patient's parents are not currently married, please indicate who has medical decision-making authority according to the legally binding divorce decree.

_____

_____

It is not the responsibility of Specialty Clinic of Austin or any of its affiliates to ensure that parents adhere to the terms of a legally binding custody agreement. If treatment decisions are not agreed upon by all parties with decision-making authority, SCOA will not continue treatment.

PREFERRED PHARMACY

Name _____ Phone No. _____

Address _____

City _____ State _____ Zip _____

Expert Care

PSYCHIATRIC & MEDICAL HISTORY FORM

What is the reason for your appointment today? *Please briefly describe your current symptoms, diagnosis, and/or treatment goals.*

_____

_____

_____

PSYCHIATRIC HISTORY

Current Therapist / Counselor (Name, Phone) _____

Previous Psychiatrist (Name, Phone) _____

Please list any psychiatric conditions that you have been diagnosed with or treated for in the past: _____

_____

_____

Please list any psychiatric medications you have been prescribed in the past. Indicate if any of these are currently being prescribed:

_____

_____

_____

Have you ever been treated in an inpatient psychiatric hospital? ..... ☐ YES ☐ NO

If YES, provide date(s), location(s), and reason(s) for hospitalization(s): _____

_____

Have you ever had thoughts or feelings that you didn't want to live? ..... ☐ YES ☐ NO

If YES, when was the last time you had these thoughts? _____

_____

Have you ever attempted suicide? ..... ☐ YES ☐ NO

Have you ever been arrested? ..... ☐ YES ☐ NO

Do you have any current or ongoing legal problems? ..... ☐ YES ☐ NO

Are you currently involved in any divorce or child custody proceedings? ..... ☐ YES ☐ NO

Have you been a victim of abuse (emotionally, sexually, physically, or by neglect)? ..... ☐ YES ☐ NO

Have you ever witnessed a traumatic event? ..... ☐ YES ☐ NO

Expert Care

PSYCHIATRIC & MEDICAL HISTORY FORM (Cont'd)

Have you ever been treated for alcohol or drug use or abuse? ☐ YES ☐ NO

If YES, please indicate for what substance and the approximate dates of treatment. _____

_____

Do you use tobacco? ☐ YES ☐ NO
Have you used any illicit drugs in the past 12 months? ☐ YES ☐ NO
Have you ever abused any prescription medication? ☐ YES ☐ NO

Have any of your family members been diagnosed with, treated for, or have suspected history of any of the following disorders?

Bipolar Disorder	☐ YES	☐ NO	Schizophrenia	☐ YES	☐ NO
Depression	☐ YES	☐ NO	PTSD	☐ YES	☐ NO
Anxiety	☐ YES	☐ NO	Substance Abuse	☐ YES	☐ NO
Anger	☐ YES	☐ NO	Violence	☐ YES	☐ NO
Psychiatric Hospitalization	☐ YES	☐ NO	Suicide or Suicide Attempt	☐ YES	☐ NO

If YES, please indicate which relative was diagnosed with this condition. _____

_____

_____

GENERAL MEDICAL HISTORY

Primary Care Physician (Name, Phone, Address) _____

_____

Approximate date of last physical exam and bloodwork _____

Are you able to provide a copy of your most recent bloodwork for our review? _____

List all medications, herbal supplements, and nutritional supplements you are currently taking, doses, and the estimated start date of each. *This includes over-the-counter medications and supplements.*

_____

_____

_____

List any medication allergies: _____

Expert Care

PSYCHIATRIC & MEDICAL HISTORY FORM (Cont'd)

Have you ever been diagnosed with or treated for any of the following conditions?

☐ High Blood Pressure	☐ Seizures	☐ Cancer	☐ Glaucoma
☐ Thyroid Disease	☐ Asthma / COPD	☐ Heart Disease	☐ Diabetes
☐ Migraine Headaches	☐ High Cholesterol	☐ Liver Disease	☐ Sleep Apnea
☐ Kidney Disease	☐ Head Injury	☐ Chronic Pain	☐ Fibromyalgia
☐ Anemia	☐ Fainting Spells / Syncope	☐ Eating Disorder	☐ Arrhythmia

Other serious or chronic illnesses: _____

_____

Do you have a history of heart arrhythmia? If so, please provide details related to this diagnosis _____

_____

Have any family members died suddenly at a young age? If so, please provide details. _____

_____

Past surgeries (include approximate dates): _____

_____

Have you ever had an EKG? ☐ YES ☐ NO

If YES, when? _____

If the results were abnormal, please provide details: _____

_____

FOR FEMALES ONLY

Date of last menstrual period: _____

Is your cycle regular or irregular? _____

Are you sexually active? ☐ YES ☐ NO

Are you currently using any form of birth control? ☐ YES ☐ NO

If YES, what type? _____

Are you currently pregnant? ☐ YES ☐ NO

Are you planning to become pregnant in the near future? ☐ YES ☐ NO

Are you currently breastfeeding? ☐ YES ☐ NO

Expert Care

Specialty Clinic
of Austin

☐ **NORTH** - Quarry Lake
☐ **SOUTH** - Southwest Medical Village

www.SpecialtyAustin.com

SYMPTOMS EXPERIENCED

Patient Name: _____ Date: _____

Please indicate if any of the following apply:

☐ For most of your life, have you had difficulty sustaining attention in tasks, failing to give close attention to details, or being easily distracted by external stimuli?

☐ For most of your life, have you been forgetful in daily activities, frequently misplaced items, struggled to stay organized, or frequently procrastinated tasks that require sustained mental effort?

☐ For most of your life, have you had difficulty fidgeting when seated, had difficulty waiting your turn or frequently interrupted others when they are busy, or talked excessively in social situations?

Please indicate if any of the following apply:

☐ Were you ever depressed or down, or felt sad, empty or hopeless most of the day, nearly every day, for two weeks or longer?

☐ Were you ever much less interested in most things or much less able to enjoy the things you used to enjoy most of the time, for two weeks?

☐ Are you currently experiencing recurrent thoughts of death, recurrent suicidal thoughts, or a suicide attempt or a specific plan for committing suicide?

Please indicate if any of the following apply:

☐ Over the past 6 months were you excessively anxious or worried about several routine things, most of the day nearly every day (such as work or school performance)?

☐ Do others think that you are a worrier or a "worry wart"?

☐ In the past month, did you have persistent fear and significant anxiety at being watched, being the focus of attention, or of being humiliated or embarrassed or rejected? (This includes things like speaking in public, eating in public, writing while someone watches, performing in front of others, or being in social situations).

☐ Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, very frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?

  ☐ Did these spells surge to a peak within 10 minutes of starting?

Please indicate if any of the following apply:

☐ Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death, serious injury, or sexual violence to you or someone else?

  ☐ Starting after the traumatic event, did you repeatedly re-experience the event in an unwanted mentally distressing way (e.g., recurrent dreams, intense recollections or memories, or flashbacks of the event) or did you have intense physical or psychological reactions when you were reminded about the event?

Expert Care

SYMPTOMS EXPERIENCED (Cont'd)

Please indicate if any of the following apply:

☐ In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, or distressing?

☐ In the past month, did you try to suppress these thoughts, impulses, or images or to neutralize or to reduce them with some other thought or action?

☐ In the past month, did you feel driven to do something repeatedly in response to an obsession or in response to a rigid rule, like washing or cleaning excessively, counting or checking things over and over, or repeating or arranging things, or other superstitious rituals?

Please indicate if any of the following apply:

☐ Have you ever had a period of time when you were feeling "up" or "high" or "hyper" and so active or full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self?

☐ Have you ever had a period of time lasting 4-7 days where several of the following symptoms were present and represented a change from your usual functioning: having elated mood; increased energy or increased activity; needing less sleep or feeling rested after only a few hours of sleep; having racing thoughts so fast it is hard for you to keep up with them; having an increase in productivity, motivation, creativity, or time spent working; engaging in reckless or impulsive behavior (excessive spending sprees, sexual indiscretions, or foolish business investments)?

☐ Have you ever peen persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family, or others felt you overreacted even in situations that you felt were justified?

Please indicate if any of the following apply:

☐ Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?

☐ Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?

☐ Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self?

☐ Have you ever believed that you were being sent special messages through the TV, radio, internet, newspapers, books, or magazines?

☐ Have you ever heard things other people couldn't hear, such as voices?

☐ Have you ever had visions when you were awake or have you ever seen things other people couldn't see?

☐ If you said yes to any of the above, do you currently believe, or are you currently experiencing, these things?

Expert Care

OFFICE POLICIES & PROCEDURES

We strive to make your experience at Specialty Clinic of Austin an enjoyable one. The following policies are in place in order to ensure fair and quality care for all of our patients. Please take a moment to read and review these policies, then initial next to each statement to indicate your understanding and agreement. Please address any questions related to these policies with your provider.

APPOINTMENTS AND PAYMENT

Please initial next to each statement to indicate your understaning and agreement.:

_____ **ARRIVAL TIME:**

Plan to arrive 10 minutes prior to your scheduled appointment time to allow adequate time to complete the check-in and payment process. **Your appointment will end at its scheduled time regardless of any time lost at check-in or due to late arrivals.**

_____ **PAYMENT AND OUTSTANDING BALANCES:**

Payment of copayments, coinsurance, deductibles, or self-pay rates is due in full at the time of service. **We will have no choice but to reschedule your appointment if you are unable to pay for your visit at the time of service** (except in the rare case of psychiatric emergencies).

- You are solely responsible for the payment of your account regardless of payment or lack of payment by any insurance carrier or other guarantor.
- **Account balances will not be allowed to accrue.** You will not be eligible to check-in for your appointment until outstanding balances are paid in full or a payment plan has been established.

_____ **INSURANCE VERIFICATION AND BILLING:**

We will submit claim forms for insurance carriers with which we are in network. For carriers we are not contracted with, you may ask us to mail you a receipt which includes the information necessary for you to file the claim.

- Your insurance carrier will provide us with an **estimate** of your copayment or coinsurance rates prior to your appointment. Please be aware that this is only an estimate (a "quote of benefits") and is subject to change until you have received an Explanation of Benefits (EOB) from your carrier. This also applies to established patients who have changed insurance carriers or insurance plans.
- You will be expected to pay for the visit in full if you do not have an updated insurance card.
- Your health insurance contract is between you and your insurance company. We cannot guarantee that all services or therapies we recommend are covered by your insurance company. **It is your responsibility to know your insurance benefits.** Any questions or complaints regarding coverage should be directed to your carrier.

_____ **INSURANCE CHANGES:**

It is your responsibility to notify our billing office if your insurance coverage changes. Please call to inform our billing office of these changes in advance of your appointment, or arrive 20 minutes prior to your appointment to speak with a billing representative in person. **Your appointment may be rescheduled if the insurance verification process delays your appointment start time.**

_____ **FOLLOW-UP APPOINTMENTS:**

You may be discharged from the practice if you fail to follow up for greater than 6 months after your last office visit, or 4 months after your recommended follow-up time frame.

- Follow-up appointments ensure the safety of patients who are continuing on medication maintenance therapy. The frequency of these appointments depends on your clinical condition and the medications utilized.
- Patients with an extended absence from care (greater than 60 days beyond the recommended follow-up time frame) will be scheduled for an appointment of extended duration to allow time for re-assessment. If you have a deductible or coinsurance, you may be responsible for a higher fee due to the extended time.

Expert Care

OFFICE POLICIES & PROCEDURES (Cont'd)

LATE CANCELLATIONS, NO-SHOWS & LATE-ARRIVALS

Please initial next to each statement to indicate your understaning and agreement.:

_____ APPOINTMENT REMINDERS:

Text message, e-mail, and telephone reminders are a courtesy service only. You are responsible for your appointment whether or not your reminder was received.

_____ LATE CANCELLATIONS & NO-SHOWS:

Appointments must be cancelled or rescheduled at least 24 hours in advance in order to avoid a Late Cancellation charge. This fee will also apply if you call to reschedule an appointment to another time slot on the same day.

- **Scheduling an appointment involves reservation of your provider's time specifically for you.** If you fail to cancel or change an appointment 24 hours in advance, we cannot bill for that time and we are unable to offer that time to another patient.
- **Insurance companies will not reimburse or cover Missed Appointment or Late Cancellation fees.** Payment of these fees is your responsibility. Late fees must be paid at the time of your next appointment.
- **You will be discharged from the practice if you provide late cancellation or fail to show up for 5 or more appointments at any time during the course of treatment** as it is difficult to provide quality care to patients who consistently miss and/or cancel their appointments.

_____ LATE ARRIVALS:

If you arrive late to your appointment, the time for your session will be reduced accordingly; you will only be seen for the remainder of the time left in your reserved appointment slot.

- Arriving late for a scheduled appointment impedes our ability to provide you with the best quality care and it often makes your clinician's schedule run behind for the remainder of the day.
- Patients arriving 10 or more minutes late to their scheduled appointment time will be offered the option to wait for another appointment time on the same day (if one is available) or to reschedule the appointment. Those who choose to wait should keep in mind that **the wait time may be considerable and unpredictable as priority is given to patients who arrive on time.** Regardless of what your situation may be, if you arrive late and choose to wait, you must wait until there is an opening. Repeated late arrivals will be charged a Late Arrival fee of $25 if they choose not to wait.
- **We strongly recommend that you arrive 10 minutes prior to your appointment** because the appointment will end at its scheduled time regardless of any time lost at check-in.

_____ NO EXCEPTIONS:

While we are very sympathetic to the fact that situations arise which may make it difficult to keep or arrive on time to a scheduled appointment, we are unable to make exceptions to this policy.

PRESCRIPTION MEDICATIONS AND REFILLS

_____ PRIOR AUTHORIZATIONS:

Prior authorizations are a courtesy service. While we make every effort to secure coverage of prescribed medications, it is ultimately your responsibility to contact your insurance company to determine which medications are covered or to request appeals for coverage decisions.

_____ ADHERENCE TO FOLLOW-UP:

Medications will only be refilled for current patients who maintain their regularly scheduled appointments. Your refill request will be denied if you have not been seen within the follow-up time frame recommended by your provider. If you are overdue for follow up and in need of a refill please call to schedule an appointment; at that time **your clinician may authorize a temporary refill. Temporary refills will not be granted for controlled substances.**

- It is your responsibility to ensure that you have enough medication to last until your next scheduled follow-up visit. We strongly recommend that you schedule your next visit prior to leaving our office as your provider's schedule may fill up quickly.
- At times our office may call to reschedule your appointment due to a conflict in your clinician's schedule. If this occurs, please check your medications to be sure you have enough to last until the date you return.

_____ HOW TO REQUEST REFILLS:

Refills may be requested by leaving a voice message or by email to info@specialtyaustin.com or controlledrefills@specialtyaustin.com.

_____ WHEN TO REQUEST REFILLS:

Refills must be requested at least 3 business days prior to running out of medication. Refill requests are not reviewed by your provider until the end of the business day so please plan accordingly.

- **Under no circumstances will medications be refilled after hours, on weekends, or on holidays.**
- A $25.00 fee is assessed for a rewrite of a controlled substance should you allow the prescription to expire.

_____ COMPLIANCE:

You are responsible for complying with your prescribed medication regimen. You should not make any changes to your medication regimen without first consulting your clinician. It is your responsibility to inform your clinician of all other medications you are taking, including over-the-counter medications and supplements.

Expert Care

OFFICE POLICIES & PROCEDURES (Cont'd)

TELEPHONE, EMAIL, AND AFTER-HOURS CONTACT

Please initial next to each statement to indicate your understaning and agreement.:

_____ COMMUNICATING WITH THE CLINIC:

At times, heavy call volume may prevent us from answering your call in person. If you reach a recording, please leave a message that includes your name, date of birth, a brief description of the nature of the issue, and information on how to be contacted. **Allow up to 24 business hours for a return call.**

- All correspondence will be transcribed by staff as part of your medical record.
- Basic questions regarding payment, insurance, and scheduling will be handled by our clinic staff. Most medical questions will be addressed by clinic staff after collaboration with your provider. **You will be asked to schedule an appointment to discuss any medication concern or symptom worsening as medication changes will not be made over the phone.**
- **If it becomes necessary to address your concern directly with your provider please be aware that these calls are limited to 5 minutes.** Any calls greater than 5 minutes are subject to fees ($25 for each 5 minute increment following the first 5 minutes). This includes telephone consultations with family members including guardians of minors.
- You may choose to communicate with the office staff or with your provider via email at:

  NORTH Location - info@specialtyaustin.com

  SOUTH Location - infosouth@specialtyaustin.com

  Be aware that email is not a secure form of communication and using it may risk the security of your protected health information. Your email communication will become part of your medical record. Email communication should never be used to communicate confidential information or urgent or emergency issues.

_____ ON-CALL CLINICIAN SERVICES:

In the event of an urgent psychiatric matter outside of regular clinic hours you may contact the on-call clinician by calling the office and following the appropriate prompts on our telephone greeting. **You will be connected with the voicemail box of the on-call clinician. Leave a brief message with your name, return phone number, and the nature of the emergency. You will receive a return telephone call promptly.**

- This service should be utilized only for urgent matters that cannot wait until the next business day (i.e., suicidal thoughts or thoughts of harming others, serious medication reactions, or unusual behavior that may lead to physical harm). Non-urgent issues (i.e., medication refills, scheduling, or billing issues) may be addressed via e-mail or by leaving a voicemail message for the clinic staff.
- **Calls placed for non-emergency issues will result in being charged a $25 fee for after-hours care.** Additionally, if the matter is not urgent or emergent you may not receive a return call from the on-call provider.

_____ EMERGENCY CARE:

In the event of a life-threatening emergency please call 911 or go to the nearest Emergency Department. Do not delay care by waiting for a response from our on-call provider.

Expert Care

OFFICE POLICIES & PROCEDURES (Cont'd)

Please initial next to each statement to indicate your understaning and agreement.:

FORMS COMPLETION, LEGAL SERVICES & OTHER SERVICES

_____ FORMS & LETTERS:

If you have forms that require your clinician's signature, please fill out all of the required information and sign the form before submitting it to the front desk staff. Do not submit forms directly to your provider.

- **We require 5-7 business days for completion of forms and letters**. Please plan accordingly by submitting these forms at least 7 business days prior to the desired submission date. **Under no circumstances will we complete forms or letters for pickup on the same day.**
- Fees will be assessed for completion of forms and letters. These fees are based on complexity and range from $25-$75. The exception is basic, one-page letters requesting 504 accommodations which will be assessed a $10 fee. These charges will be your responsibility and will be charged to your account.

_____ LEGAL TESTIMONY:

It is often unforeseen but legal matters requiring the testimony of a mental health professional can and do arise. Legal testimony can often be damaging to the relationship between a patient and his or her clinician. As such, we require that you employ independent forensic psychiatric services should this type of evaluation or testimony be required.

- If for any reason any of our clinicians is deposed or subpoenaed on your behalf and required to testify or appear in court, you will be responsible for our court fees which are $4500 per day and will not be prorated (because attending court necessitates blocking the clinician's schedule for the entire day). This fee must be paid upfront and in full.
- **We will not complete custody evaluations or parental assessments for use in determining custody or visitation, CPS evaluations, or disability evaluations. You must find a forensic professional to assist you in these purposes.**

_____ OTHER PROFESSIONAL SERVICES:

Any other professional service that requires longer than 5 minutes (i.e., telephone consultations, report writing, preparation of treatment summaries, communication or coordination of care with other providers or family members) or time spent performing any other services on your behalf will be charged $25 for each additional 5-minute increment.

TREATMENT OF MINORS

Please see addendum regarding treatment of minors of divorced parents for additional policies related to this unique situation.

_____ Minors 17 years of age or younger must be accompanied by a parent or legal guardian. Under no circumstances will medication changes be authorized without a parent or legal guardian present.

TERMINATION OF CARE

_____ At times, termination of care between a patient and provider is necessary. Termination of treatment may occur at any time and may be initiated by either the patient or the provider.

_____ **We will assume that you have terminated care if you fail to show up for a scheduled appointment and do not contact our office within 60 days of this missed appointment, or you do not schedule and attend a follow up appointment within 6 months of your last scheduled appointment.**

AGREEMENT

My signature below indicates that I have read the office policies document in full, I understand all of its provisions, and I agree to abide by these policies throughout the course of my professional relationship with Specialty Clinic of Austin and any of its associates. I understand that I may request a copy of this document at any time. I understand that violation of any of these policies is grounds for termination of care.

☐ I agree that my electronic signature on this application is binding and enforceable, as if I had signed a paper copy.

Patient Name:

_____

Date: _____

Patient Signature (or Legal Guardian, if a minor):

_____

Expert Care

CONTROLLED SUBSTANCES FORM

Controlled medications (i.e., benzodiazepines, stimulants, hypnotic sleep aids) have a high potential for misuse and are, therefore, closely regulated by local, state, and federal governments. Our clinicians must observe strict rules in order to minimize the risks of abuse and misuse. All patients at Specialty Clinic of Austin (SCOA) must agree to follow the policies outlined in this agreement as a condition of the provision of controlled substance medications by my clinician.

Please initial next to each statement to indicate your understaning and agreement.:

_____ I understand that consumption of controlled substances is associated with risks including, but not limited to, psychological addiction, physical dependence, withdrawal, and overdose.

_____ I agree to utilize the prescribed medication as instructed. Changing the way I take my medication (i.e., taking my medication more than as directed or abruptly stopping my medication) is prohibited and can result in adverse health outcomes.

- I will not alter the date, quantity, and/or strength of my prescribed medications. I will not break, chew, crush, inject, or snort my medications.
- I will not alter a prescription by any means, shape, or form. Forging prescriptions and/or my clinician's signature violates state and federal law.
- I agree to keep my prescription(s) in a secure and safe location and to safeguard my prescription(s) against loss or theft. I will not sell my medication or share it with others, or in any other manner enable other individuals to possess or use my prescribed medications.

_____ **I understand that absolutely no premature refills will be granted regardless of the circumstances (i.e., stolen, misplaced, mislaid, exceeding prescribed dosages, losing a handwritten prescription prior to filling, etc.).** I must wait until the next eligible fill date to receive another prescription.

- **I may be discharged from the clinic if I request an early refill secondary to lost, damaged, or stolen prescriptions twice within one year.**

_____ I understand that my clinician follows state and federal recommendations regarding the use of urine toxicology screens to monitor controlled substances use. **I agree to cooperate with urine toxicology screenings, which will be ordered by my clinician prior to prescribing a controlled substance and randomly during the course of my treatment.**

- **Any charges associated with the toxicology screen will be my responsibility if they are not covered by my insurance carrier.**
- Refusal to consent to toxicology screens, the presence of nonprescribed or illicit substances in my sample, or the absence of prescribed medications in my sample will result in discontinuation of controlled substances and may result in termination of care.
- In the event of inconsistent results, my clinician may contact me to present to the office for a follow-up test; if I fail to present within 24 hours of receiving this phone call my controlled substance prescriptions will be terminated. **I must keep my contact information current so my clinician may reach me, as any missed tests will be considered to be a violation of this agreement.**

Expert Care

CONTROLLED SUBSTANCES FORM (Cont'd)

Please initial next to each statement to indicate your understaning and agreement.:

_____ I will obtain all medications for the treatment of my psychiatric condition solely from SCOA unless previous clearance has been obtained by my SCOA clinician. I will not obtain controlled substance prescriptions from multiple providers. If I receive other controlled substance prescriptions from any source other than my SCOA clinician, without notifying my SCOA clinician, I will be discharged from the clinic.

- I understand and consent that my clinician can and will utilize the following resources to obtain a history of my prescribed medications: requesting information from my past/current treating physician, requesting information from my current or previous pharmacy, and conducting a Department of Public Safety (DPS) report through the State of Texas several times per year (Texas Prescription Drug Monitoring Database). My DPS reports will become part of my medical record.
- I will communicate with other providers who are treating me that I am under a controlled substance agreement with SCOA. I consent to release this agreement information to other providers, emergency departments, pharmacies, and consultants to allow pharmacies to release my prescription history. I also consent for other providers, emergency departments, pharmacies, and consultants to report violations of this agreement to SCOA and my primary care provider.

_____ I understand that changes in any controlled substance prescription will only be made in the context of a clinic visit and never via telephone and/or during non-clinic hours.

- Refills are exclusively provided as determined by my clinician, will only be granted if I keep my scheduled appointments, and will not be granted outside of regular business hours.

_____ I agree to inform my clinician of any new medications or medical conditions that arise during the course of my treatment. I will notify my clinician of any adverse effects I experience from any of the medications I consume.

_____ I will inform my clinician of any current or past substance abuse. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

- I agree not to use alcohol or any illegal substances (including, but not limited to, marijuana, heroin, cocaine, and amphetamines) while under this agreement.
- I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances which impairs my driving ability, may result in DUI charges and/or other legal charges.

_____ I understand that if I violate any of the above policies, all orders for my controlled substance prescriptions will cease and I will be dismissed from the clinic.

- I understand that my clinician fully cooperates with local, state, and federal law enforcement agencies as well as the Drug Enforcement Agency (DEA) and the Department of Public Safety (DPS) in regards to infractions involving prescription medications. My pharmacy, local authorities, and the DEA will be notified if my treating clinician believes that I have violated the laws regarding controlled substance prescriptions in any manner.
- If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtain medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substance administration.

Expert Care

ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCES AGREEMENT

I have read and understand the policies regarding controlled substance prescriptions. I voluntarily agree to the terms involved in the Controlled Substances Form. I understand that if any of the above policies are violated or I choose not to adhere to these policies, I will be dismissed from this clinic and will not receive any refills from the treating clinician.

☐ I agree that my electronic signature on this application is binding and enforceable, as if I had signed a paper copy.

Patient Name: _____ Date: _____

Patient Signature (or Legal Guardian, if a minor): _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF HEALTH INFORMATION

Protected health information (PHI) is the information that Specialty Clinic of Austin (SCOA) or any of its affiliates creates and obtains in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnoses, treatment, and applying for future care or treatment; it also includes billing documents for those services. This office is permitted by federal privacy laws to make uses and disclosures of your health information for the purposes of treatment, payment, and health care operations. Examples of uses of your health information for these purposes are:

- **Treatment:** SCOA may use and disclose your PHI to other professionals who are treating you (i.e., a doctor treating you for an injury asks us about your overall mental health condition; your SCOA clinician determines that he/she needs to consult with a specialist and provides your information to obtain his/her input). Additionally SCOA discloses PHI for appointment reminders, treatment alternatives, or health-related benefits/services including identifying patients who are qualified to participate in clinical research trials through our associates (including but not limited to BioBehavioral Research of Austin). We may use or disclose your PHI to provide you with appointment reminders (such as voicemail messages, e-mails, text messages, postcards, or letters).
- **Payment:** SCOA may use and disclose your PHI to bill and obtain payment for services we provide to you (i.e., we give information about you to your health insurance plan so it will pay for your services).
- **Healthcare Operations:** We may use and disclose your PHI in connection with our healthcare operations including quality assessment and improvement activities, outcome evaluation, protocol and clinical guideline development, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities, medical review, legal services, and insurance. We will share your PHI with insurers or other business associates as necessary to obtain and conduct these services.

How else can we use or share your PHI? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. For more information see: www.hhs.gov/orc/privacy/hipaa/understanding/consumers/index.html

- **Comply with the law:** We will share your PHI if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to lawsuits and legal actions:** We can share your PHI in response to a court order or administrative order, or in response to a subpoena.
- **Public health and safety issues:** We can share your PHI for certain situations such as: preventing or controlling disease, injury, or disability; helping with product or pharmaceutical recalls; reporting adverse reactions to medications; reporting post-marketing surveillance information; assisting in disaster relief efforts; reporting suspected abuse, neglect, or domestic violence; and preventing or reducing a serious threat to the health or safety or a person or the public.
- **Conduct research:** We can use or share your PHI for health research when the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
- **Address workers' compensation, law enforcement, and other government requests:** We can use or share your PHI for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services. We can release your PHI to your employer if we provide services to you at the request of your employer, and the healthcare services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. This includes disclosure of PHI to the extent necessary to obtain services related to Family Medical Leave Act, Workers Compensation, and/or disability claims.
- **Work with a medical examiner or funeral director:** We can share PHI with a coroner, medical examiner, or funeral director when an individual dies.
- **Respond to organ and tissue donation requests:** We can share your PHI with organ procurement organizations.
- **Communication with family and close friends:** Using our best judgement, we may disclose to a family member, other relative, close personal friend, or any other person you identify, PHI relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency. Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location and about your general condition, or your death.
- **Other Uses:** Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

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NOTICE OF PRIVACY PRACTICES (Cont'd)

PATIENT RIGHTS: The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. When it comes to this information, you have a right to:

- **Provide Authorization:** In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.
- **Access:** You have the right to see or get copies of your medical record and other PHI with limited exceptions. You may exercise this right by delivering the request to our office. If you request copies, we will provide them within 30 days of your request. We will charge a reasonable, cost-based fee. You may appeal a denial of access to your PHI, except in certain circumstances.
- **Amendment:** You have the right to request that we amend incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the PHI kept by or for the office; is not part of the information that you would be permitted to inspect and copy; or, is accurate and complete. If your request is denied, you will be informed of the reason for denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. You may request that communication of your PHI be made by alternative means or at an alternative location by delivering the request in writing to our office. We will say "yes" to all reasonable requests.
- **Request restrictions:** You have the right to request restrictions on certain uses and disclosures of your PHI by delivering the request to our office. We are not required to grant the request unless the requested restriction is for the disclosure to a health plan for purposes of carrying out payment or healthcare operations (and is not for purposes of carrying out treatment) and the PHI pertains solely to the healthcare item or service for which we have been paid out of pocket in full.
- **Revoke authorizations:** You may revoke authorizations that you made previously to use or disclose PHI by delivering a written revocation to our office, except to the extent information or action has already been taken.
- **Obtain a list of disclosures:** You can ask for a list of the times we've shared your PHI, who we shared it with, and why, by delivering a written request to our office. This list will not include disclosures of information for treatment, payment, and health care operations, or certain other disclosures (such as disclosures you asked us to make, disclosures made pursuant to an authorization signed by you, disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for your care, or disclosures to notify family or others responsible of your location, condition, or your death). We can charge a reasonable, cost-based fee for provision of this list.
- Obtain a copy of this notice: You can ask for a paper copy of this notice at any time by making a request at our office.

You may exercise any of the above rights by contacting: Jessica Ramirez, Office Manager, at 4515 Seton Center Parkway, #175, Austin, TX, 78759; phone 512-382-1933, in person or in writing, during regular business hours. She will inform you of the steps that need to be taken to exercise your rights.

OUR RESPONSIBILITIES: This office is required by law to maintain the privacy and security of your PHI; provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; notify you of any breach of your unsecured PHI; abide by the terms of this Notice; notify you if we cannot accommodate a requested restriction or request; and, accommodate your reasonable requests regarding methods to communicate PHI with you.

Your PHI may be released electronically.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the PHI we maintain. If our information practices change, we will amend our Notice. You are entitled receive a revised copy of the Notice by calling and requesting a copy or by visiting our office to pick up a copy.

QUESTIONS AND COMPLAINTS: If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Jessica Ramirez, Office Manager, 4515 Seton Center Pkwy, #175, Austin, TX 78759 or by calling 512-382-1933. If you believe your privacy rights have been violated, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may file a written complaint at our office by delivering the written complaint to Jessica Ramirez. You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights, by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 1-877-696-6775. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

APPLIED ORGANIZATIONS:

This Notice of Privacy Practices applies to the following organizations:

Specialty Clinic of Austin North, Specialty Clinic of Austin South, and BioBehavioral Research of Austin, which operates the clinical research services within all Specialty Clinic of Austin locations in the greater Austin area.

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PRACTICES ACKNOWLEDGEMENT AND CONSENT TO TREATMENT

As the patient or their legal representative, I hereby request and consent to psychiatric services for myself/dependent which includes routine/crisis screening, examination, diagnostic assessment, laboratory screenings and procedures, and other treatments/services (e.g., psychotherapy, medication management, referral for psychological testing) recommended by my clinician, his/her assistants, or designee as is necessary in his/her judgement. I understand that I have the option to accept or reject any recommendations for services.

I authorize my clinician and Specialty Clinic of Austin to use and disclose my personal health information to receive payment for the care I receive. I have received a copy of the Notice of Privacy Practices with further details on how my health information may be used, and I have been provided an opportunity to review it. I have also been informed that identifying information about me may be exchanged between the clinicians at Specialty Clinic of Austin or its affiliates for coverage purposes or continuity of care purposes.

I have been advised that I am financially responsible for any services provided by any provider at Specialty Clinic of Austin or its affiliates. I agree to be responsible for all charges during my treatment. I have been notified that some services may not be covered under my insurance plan and I am financially responsible for any non-covered services. If the office files a claim to my insurance carrier, I authorize payment of medical benefits to be made to my clinician. In the event my insurance carrier does not pay my claim within a reasonable amount of time (60 days) I may be billed for services provided. I have read and acknowledge the receipt of the office financial policies in the Office Policies and Procedures document.

I understand that if I do not call at least 24 business hours in advance of a scheduled appointment to cancel or reschedule an appointment I will be charged a missed appointment fee. I understand that if I arrive 10 or more minutes late for a scheduled appointment I will be asked to wait and may be asked to reschedule my appointment.

My signature below indicates that I have read the Notice and Office Policies documents and agree to all terms.

☐ I agree that my electronic signature on this application is binding and enforceable, as if I had signed a paper copy.

Patient Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Patient Signature (or Legal Guardian, if a minor): _____

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