BEYOND PSYCHIATRY BEHAVIORAL HEALTH

150 E Medical Center Blvd, Suite A. Webster, TX.77598
Phone: 281-481-4646 Fax: 281-481-4649
www.beyondpsychiatry.com

PATIENT INFORMATION

Last Name: _____First Name: _____Middle Name: _____
Suffix (Circle): Jr Sr III IV Date of Birth:_____ Gender: □ Male □ Female
Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ SSN: ____-____-_____
Spouse Name: _____ Spouse Number: (_____) _____-_____
Home Address: _____
City: _____State:_____ Zip Code: _____
Phone No: Home: (____) _____ - _____Mobile :(_____) _____-_____

*Email: _____
*Your email will be used to invite you to access to our Patient Portal.
Race: □ Caucasian □ African-American □ American Indian/Alaskan Native
□ Pacific Islander □ Asian □ Other
Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown Language: □ English Other: _____
Where did you find us? □ Online, google search □ Website □ Yelp □ other: _____

EMERGENCY CONTACT

Contact Name: _____ Relationship: _____
Home Phone: (_____) _____-_____ Mobile: (_____) _____-_____

PATIENT STUDENT/ EMPLOYMENT DETAILS

Student Status: □ Full-Time □ Part-Time □ Not a Student School Name:
Employment Status: □ Full-Time □ Part-Time □ Not Employed □ Self-Employed □ Military Duty
Employer Name: Work: (_____) _____-_____
Address: _____City: _____State: ___ Zip: _____

REFERRAL AND PCP

Referring Physician Name: _____Phone Number: (____) _____-_____
PCP Name: _____ Phone Number: (____) _____-_____

LABS AND PHARMACY

Please tell us which lab company you normally use, and your local pharmacy and mail order pharmacy you use to fill your prescriptions:
Lab: □ Quest □ Labcorp □ Any Test Now □ Other: _____
Pharmacy: □ CVS □ H-E-B □ Sam's Club □ Target □ Walgreens □ Walmart Other: _____
Address and Phone Number: _____ (____) _____-_____

Mail Order Pharmacy: □ CVS Caremark □ Express Scripts □ Prime Mail □ Other: _____

Address and Phone Number: _____ (____) _____-_____

FINANCIAL RESPONSIBILITY

Primary Insurance Name: _____Behavioral Phone Number: _____

Member ID Number: _____Group Number: _____

Insurance Claim Address (Back of Card): _____

Policy Holder: □ Self Other: _____

Policy Holder DOB: ____ /___/____ SSN: _____-_____-_____

Secondary Insurance Name: _____ Behavioral Phone Number: _____

Member ID Number: _____Group Number: _____

INSURANCE ASSIGNMENT AND SELF PAY AGREEMENT

I certify that I have insurance coverage with the primary insurance company and the second insurance payer, if applicable, listed above. I assign directly to Beyond Psychiatry Behavioral Health, all insurance payments, if any otherwise payable to me for services rendered. I understand I am financially responsible for deductible, co-payments, co-insurance amounts, non-covered charges, and any balances not covered under a signature for all insurance submissions. I request that payment of authorized Medicare benefits and if applicable, Medigap benefits, I understand that it is my responsibility to pay for services rendered at the time of visit.

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

Payment for services rendered is the responsibility of the patient, parent, or guardian. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage on your behalf. ***However, you are ultimately responsible for the payment of your bill, regardless of insurance coverage.*** If additional funds are required after the insurance claim has been processed, any balance will be billed to the patient. If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the patient. If insurance issues arise, it is the responsibility of the patient to contact the insurance company, group plan, administrator, or employer representative for resolution. A patient's insurance policy is a contract between the patient and the insurance carrier. Beyond Psychiatry Behavioral Health and its associates are not parties to that contract and cannot act as a mediator with the carrier or employer. The patient will become responsible for complete payment to the provider if coverage is terminated due to lack of premium payment. As required by insurance mandates, it is the responsibility of the patient to obtain any necessary authorization for medical treatments. If a referral is required for treatment, it is the responsibility of the patient to obtain the referral and present it at the time of treatment. If the patient is treated without the proper referral or authorization as required by the insurance carrier, the patient assumes responsibility for payment of all fees at the time of service.

PATIENT OR FAMILY NAME: _____SIGNATURE: _____ Date: _____

CONSENT FOR OFFICE POLICIES AND PATIENT PORTAL POLICIES AND PROCEDURES

I hereby give consent for Beyond Psychiatry Behavioral Health and their business associates (such as, but not limited to medical billing company, EHR vendor, collection agency, automated appointment reminder vendor, dictation service, and electronic prescription vendor) to use and disclose protected health information about me to carry out treatment, payment, and health care operations. You can ask for a copy of the Notice of Privacy Practices provided by Beyond Psychiatry Behavioral Health, which describes such uses and disclosure in detail.

I have the right to review the Notice of Privacy Practices prior to signing this consent Beyond Psychiatry Behavioral Health, reserves the right to revise its Notice of Privacy practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to privacy officer 150 E. Medical center Blvd, Suite A, Webster. Texas 77598. You can also pick up a copy in our office.

With this consent, Beyond Psychiatry Behavioral Health, may communicate to me in reference to any items that assist the practice in carrying out TPO, such as, but not limited to appointment reminders, billing statements, insurance issues and any message pertaining to my clinical care including lab results, among others by use of phone calls to my home, mobile or other alternative location and speak or leave a message, text message, email, postal delivery and or by Patient Portal. By signing this form, I am consenting to allow Beyond Psychiatry Behavioral Health to use and disclose my PHI to carry out to TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Beyond Psychiatry Behavioral Health may decline to provide treatment to me. I understand and agree with all the preceding information unless otherwise indicated in writing. I agree and accept the terms of all these documents.

PATIENT NAME: _____SIGNATURE: _____DATE:_____

CONFIDENTIAL INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I understand that as a client of the providers here at Beyond Psychiatry Behavioral Health, I may be provided with a range of counseling services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks to months and maybe for years.

I understand that all information obtained at Beyond Psychiatry Behavioral Health is confidential and no information will be shared without my consent. I acknowledge that during the course of my treatment information may be shared with other health care providers in the offices of Beyond Psychiatry Behavioral Health.

I further understand that there are specific and limited expectations to this confidentiality which include the following:

A. When there is a risk of imminent danger to myself or to another person, the clinician is bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and inform proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that while psychotherapy and/or medication may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to recall of troubling memories. Medications may have unwanted side effects. I understand that I need to continue medical care with my primary care physician (PCP) and notify the providers at Beyond Psychiatry Behavioral Health.

PLEASE NOTE: *If I cancel my appointment within 24 hours or miss my appointment or no show on the day of appointment, I will be charged a $50 fee. If I have more than 3 consecutive cancellations or no shows, then I will receive a termination of contract letter.* If, at a later time if my circumstances change and I am able to commit to my treatment sessions, then I am welcome back to start my treatment again. Upon

termination of treatment, the provider will assist me in finding another provider for continuity of care. At Beyond Psychiatry Behavioral Health, we utilize a comprehensive treatment plan. This means that we may consult your current health care providers in order to provide a thorough treatment plan. At times it is necessary to make referrals to other providers such as substance abuse treatment, medication evaluation or testing, etc.

If I have any questions regarding this consent form or about the services offered by the providers of Beyond Psychiatry Behavioral Health and its associates, I may discuss them with my providers.

I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Beyond Psychiatry Behavioral Health and its Associates, and I understand I can stop treatment at any time.

PATIENT NAME: _____

FAMILY OR GUARDIAN NAME: _____

SIGNATURE: _____DATE:_____

AUTHORIZATION TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

PATIENT NAME: _____DATE OF BIRTH: ___/___/___

I understand that the purpose of this release is to assist with my treatment by improving communication between professional service providers or agencies and the important individual(s) in my life. To further this goal, I authorize Beyond Psychiatry Behavioral Health and its associates to release and receive the below-specified information regarding me/the client to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

All patient information is to be disclosed with the exception of items written below, these items will NOT be disclosed:

_____

This information is to be disclosed to these persons, who have the indicated relationship to me/the patient:

Name of person: _____Relationship:_____

Name of person: _____Relationship:_____

Name of person: _____Relationship:_____

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire upon my discharge from treatment.

Patient Signature: _____ Date: _____

Signature of parent/guardian: _____Date:_____

Printed name of parent/guardian: _____Date: _____

CONTROLLED SUBSTANCES POLICIES AND ACKNOWLEDGEMENT

Please read carefully and sign for your medical record. A copy will be given to you on request.

I will use my medication(s) exactly as directed by my provider.

I agree not to share, sell or otherwise permit others, including my family and friends, to have access to my medications.

I will not allow or assist in the misuse/diversion of my medication(s); nor will I give or sell them to anyone else. All medication(s) will be obtained at one pharmacy, where possible. Should the need arise to change pharmacies, I will inform my provider. I will use only one pharmacy and I will provide my pharmacist a copy of this form. I authorize my provider to release my medical records to my pharmacist as needed.

I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication (s) are specific to my plan of care. If either are lost or stolen, they will NOT BE REPLACED. Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) are allowed when) I am Traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.

I will receive medication(s) only from ONE provider unless it is for an emergency or the medication(s) that is being prescribed by another provider is approved by my provider. Information that I have been receiving medication(s) prescribed by other providers that has not been approved by my provider may lead to a discontinuation of medication(s) and treatment.

If it appears to my provider that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my provider may try alternative medication(s) or may taper me off all medication(s). I understand that discontinuation of medications may cause withdrawal symptoms.

I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., this controlled substances treatment may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified provider such as an addictionologist or a provider who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

I agree that I will inform any provider who may treat me for any other medical problem(s) that I am taking controlled substances, since the addition of other medication(s) may cause harm to me. I hereby give my provider permission to discuss all diagnostic and treatment details with my other provider(s) and pharmacist(s) regarding my use of medications prescribed by any other provider(s).

I will take the medication(s) as instructed by my provider. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

I will keep all follow-up appointments as recommended by my provider or my treatment may be discontinued.

I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and signing this form while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

PATIENT NAME: _____SIGNATURE:_____ DATE: _____

HEALTH SCREENING INFORMATION

PAST PSYCHIATRIC HISTORY OR TREATMENT

Have you ever being diagnosed or treated for any psychiatric disorders◯ No◯ Yes, if yes please answer below

Current therapist: ◯ No ◯ Yes, if yes Name of therapist's address/telephone #:

_____

Have you ever being told, informed, diagnosed or treated for any of the following conditions:

◯ Bipolar Disorder ◯ Depression ◯ Schizophrenia ◯ Anxiety Disorders ◯ ADHD/ ADD◯ Alzheimer's disease or Dementias ◯ Alcohol or substance abuse ◯ PTSD ◯ Self harming or Cutting behavior ◯ Suicide Gestures / Attempts

If any box is checked, please describe:

_____

Have you ever been hospitalized for mental health reasons: ◯ No ◯ Yes, if yes, please describe? How many time(s), Reason(s) and most recent hospitalization.

_____

History of suicidal thoughts or threats: ◯ No ◯ Yes, if yes, please describe:

_____

Suicidal gestures and/or attempts: ◯ No ◯ Yes, if yes, please Describe:

_____

Any legal history: ◯ No ◯ Yes, if yes, please describe:

_____

History of involvement in lawsuits: ◯ No ◯ Yes, if yes, please describe:

_____

History of Substance abuse treatment for Alcohol or Drugs use ◯ No ◯ Yes, if yes, please describe:

_____

FOR WOMEN ONLY:

Date of last menstrual period: _____
Are you currently pregnant, or think you may be pregnant? ◯ Yes ◯ No
Are you planning on getting pregnant in the near future? ◯ Yes ◯ No
(Please notify your psychiatrist or provider immediately in case you get pregnant while you are on psychiatric medications) Birth control method: _____

CURRENT PSYCHIATRIC MEDICATIONS ◯ None, Not taking any medications

NAME	DOSAGE

ALLERGIES / INTOLERANCES: ◯ None ◯ (NKDA- No Known drug allergies)

_____

MEDICAL HISTORY
Check any medical conditions you have been diagnosed with.

◯ High blood pressure ◯ Diabetes ◯ Coronary Artery Disease / Heart Diseases ◯ Atrial fibrillation (A-Fib) ◯ Congestive heart failure ◯ Angina / Heart Attack ◯ Blood Clots ◯ Anemia ◯ Stroke /CVA ◯ TIA ◯ Legal Blindness ◯ Hearing Impairment◯ Glaucoma ◯ Cataract ◯ High Cholesterol ◯ COPD ◯ Asthma ◯ Sleep Apnea ◯ Seizure disorder ◯ Migraine Headaches ◯ chronic pain◯ Osteoporosis ◯ Rheumatoid Arthritis ◯ Osteoarthritis ◯ Urinary Incontinence ◯ Benign Prostatic Hypertrophy (BPH) ◯ Peptic Ulcer Disease ◯ Irritable Bowel Syndrome ◯ GERD ◯ Renal Disease ◯ Liver Disease ◯ Gallbladder Disease ◯ Thyroid Disease ◯ Cancer ◯ Hepatitis-C

◯ All Others: _____

SURGICAL HISTORY
◯ Gall bladder ◯ Appendix ◯ Knee Replacement surgery ◯ Cataract ◯ Heart surgeries ◯ CABG ◯ Stent placement ◯ Hysterectomy ◯ Brain surgery

◯ All Others: _____

FAMILY MEDICAL HISTORY

Please check all family medical history

◯ Hypertension ◯ Diabetes ◯ Heart Diseases ◯ Atrial fibrillation ◯ Congestive heart failure ◯ Renal Disease◯ Glaucoma v Cataract ◯ GERD ◯ COPD ◯ Asthma ◯ Sleep Apnea ◯ Thyroid Diseases ◯ CVA/Stroke ◯ Seizure disorder ◯ All Others _____

FAMILY PSYCHIATRIC HISTORY

History of psychiatric or psychological disorders in family ◯ No ◯ Yes if yes, has anyone in your family ever been diagnosed or treated for any of the following? Check all that apply.

◯ Bipolar Disorder ◯ Depression ◯ Schizophrenia ◯ Anxiety Disorders ◯ ADHD/ ADD ◯ Alzheimer's disease or Dementias ◯ Alcohol or substance abuse ◯ Suicide or suicide attempts

If any box is checked, Please give more details (which family member, dates etc.)

_____

History of substance abuse in the family ◯ No ◯ Yes, if yes please describe:

_____

Is there a history of suicide in the family? ◯ No ◯ Yes, if yes please describe:

_____

Thank you! We appreciate your patience and cooperation in providing pertinent personal, medical, health insurance information, reviewing and signing office policies and consent forms.