PSYCHIATRY & BEHAVIOR
CENTER RICHMOND

7790 West Grand Parkway South,
Suite 103 Richmond TX 77406

PATIENT INFORMATION FORM

Appointment with Dr: _____

Patient Name: _____

Date of Birth: _____

Age: _____ **Sex:** ☐ **Male:** ☐ **Female** **Race:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell No:** _____

Email Address: _____

Social Security No: _____ **Drivers License No:** _____

Marital Status: _____ **Referral Name:(Required)** _____

Consent to release for PCP: ☐ **YES** ☐ **NO**

Fax: _____

Pharmacy Name: _____

Pharmacy #: _____

Fax: _____

PAYMENT INFORMATION

Type of Payment: _____ **Insurance:** _____ **Self/Other:** _____

Insurance Company: _____

Policy Holder Name: _____

Date of Birth: _____

Social Security No: _____

Policy Number: _____ **Group No:** _____

Employer Name: _____ **Work Phone:** _____

Employer Address: _____

City: _____ **State:** _____ **Zip Code:** _____

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In Case Of Emergency, Please Contact:

Name: _____ **Phone:** _____ **Alt Phone:** _____

Relationship: ☐ **Spouse** ☐ **Parent** ☐ **Guardian** ☐ **Other**

Other Payment is expected at the time services are rendered unless prior arrangements are made. If you have insurance coverage please give your insurance card/s to the receptionist to copy.

Signature: _____ **Date:** _____

Patients Rights and Responsibilities

As a patient you have certain rights:

- You have the right to dignity as an individual human being.
- You have the right to equal consideration and treatment regardless of your sex, age, race, religion, color, economic status, or sexual preference.
- You have the right to be provided with professional and respectful care.
- You have the right to confidentiality. No information will be released without your written consent except as required by law. In general, issues of suicide, homicide, and child abuse require actions (and release of information) without your consent. There are other specific areas of the law, which may terminate your right of confidentiality.
- You have the right to know our assessment of the problem, the recommended treatment, and resources available to help improve this problem.
- You have the right to refuse treatment. Even though your counselor may strongly suggest you seek help, you may choose to not follow the counselor's advice. Should you choose to refuse treatment, you will be apprised of consequences that may result from your refusal. Alternatives may be available.

Along with these rights go certain responsibilities, These are:

- To be honest, open and willing to share your concerns with your clinician.
- To ask questions when you do not understand or need clarification.
- To discuss any reservations you have about your treatment plan with your clinician.
- To follow the treatment plan agreed upon.
- To report changes or unexpected events as related to your problem with your clinician.
- To remember your appointment date and time, it is **your** responsibility. (Our office reminder call is only a courtesy) .

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- To cancel an appointment 24 hours prior to your scheduled appointment date and time; **otherwise, you will be charged $35.00.**
- Remember that you are responsible for your thoughts, feelings, actions, and your growth.
- We are here to help you to the best of our ability.

Please sign below indicating you have read and understand your rights and responsibilities.

Signature: _____ **Date:** _____

POLICIES & PROCEDURES

- Patient management requiring phone calls, letters, review of records and other clinician time other than appointments are subject to a charge.
- Payment for professional services rendered is required at the time of the initial consultation and at the time of each additional session unless other arrangements have been made with this office in advance.
- If arrangements are made for us to bill your insurance, managed care company, EAP or PPO, **You will be responsible for any co-payment or deductible required by your insurance plan and payment should be made at the time of service rendered.**
- In the event that your insurance coverage terminates or does not remit reimbursement during the course of treatment, payment for services become your responsibility and is required at the time of each visit.
- **24 hours prior to your appointment,** notify our office of any changes in your **Insurance status**. Please be advised that payment for services will be your responsibility at the time of your appointment if our office is not notified of insurance changes or updates 24-hours prior to your appointment date.
- It is your responsibility (and/or parent-guardian's) to cancel/reschedule an appointment.
- It is your responsibility (and/or parent-guardian's) to remember your appointment date and time.
- Reminder calls for appointments are a COURTESY provided by our office.
- **24 hours prior to your appointment**, notify our office of any change in your **Appointment status**, otherwise, you will be charged **$35.00** for non-cancelled appointments. Your insurance plan will not cover these charges therefore, payment is your responsibility.
- Please be advised that we only accept CASH, CHECK, or CREDIT CARD (Visa, MasterCard, Discover, and American Express) for payments
- There is a **$25.00** charge for returned checks, **plus** original amount of check, **plus** additional bank charges.

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- **Agreement of Policy & Procedures**

My signature below indicates that I understand and accept the above-listed policies.

Signature: _____ **Date:** _____

- **Authorization to Release Information**

I hereby authorize my physician/psychotherapist to release any information acquired in the course of my examination or treatment necessary to satisfy medical insurance claims.

Signature: _____ **Date:** _____

- **Authorization to Pay Benefits to Physician/Psychotherapist**

I hereby authorize payment directly to physician/psychotherapist for medical benefits.

Signature: _____ **Date:** _____

HIPPA
Notice of Privacy Practices

- I have read and understand the “HIPPA” Notice of Privacy Practices and received a copy for my records. For teaching/learning purposes I give my consent to have medical students/physician to be present during my psychiatric evaluation. I allow these students to take my vitals and psychiatric history.

Signature: _____ **Date:** _____

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LIST OF CURRENT MEDICATIONS

Name _____ Date _____

1. _____
a. Dosage _____
b. Frequency _____

2. _____
a. Dosage _____
b. Frequency _____

3. _____
a. Dosage _____
b. Frequency _____

4. _____
a. Dosage _____
b. Frequency _____

5. _____
a. Dosage _____
b. Frequency _____

6. _____
a. Dosage _____
b. Frequency _____

7. _____
a. Dosage _____
b. Frequency _____

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Name: _____ Date: _____

CUXOS ANXIETY SCALE

INSTRUCTIONS:
This scale includes questions about the symptoms of anxiety. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

0=not at all true	1=rarely true	2=sometimes true	3=often true	4=almost always true

During the PAST WEEK, INCLUDING TODAY....

1. I felt nervous or anxious	○ 0	○ 1	○ 2	○ 3	○ 4
2. I worried a lot that something bad might happen	○ 0	○ 1	○ 2	○ 3	○ 4
3. I worried too much about things.	○ 0	○ 1	○ 2	○ 3	○ 4
4. I was jumpy and easily startled by noises.	○ 0	○ 1	○ 2	○ 3	○ 4
5. I felt "keyed up" or "on edge."	○ 0	○ 1	○ 2	○ 3	○ 4
6. I felt scared.	○ 0	○ 1	○ 2	○ 3	○ 4
7. I had muscle tension or muscle aches.	○ 0	○ 1	○ 2	○ 3	○ 4
8. I felt jittery.	○ 0	○ 1	○ 2	○ 3	○ 4
9. I was short of breath.	○ 0	○ 1	○ 2	○ 3	○ 4
10. My heart was pounding or racing.	○ 0	○ 1	○ 2	○ 3	○ 4
11. I had cold, clammy hands.	○ 0	○ 1	○ 2	○ 3	○ 4
12. I had a dry mouth.	○ 0	○ 1	○ 2	○ 3	○ 4
13. I was dizzy or lightheaded.	○ 0	○ 1	○ 2	○ 3	○ 4
14. I felt sick to my stomach (nauseated).	○ 0	○ 1	○ 2	○ 3	○ 4
15. I had diarrhea.	○ 0	○ 1	○ 2	○ 3	○ 4
16. I had hot flashes or chills.	○ 0	○ 1	○ 2	○ 3	○ 4
17. I urinated frequently.	○ 0	○ 1	○ 2	○ 3	○ 4
18. I felt a lump in my throat	○ 0	○ 1	○ 2	○ 3	○ 4
19. I was sweating.	○ 0	○ 1	○ 2	○ 3	○ 4
20. I had tingling feelings in my fingers or feet.	○ 0	○ 1	○ 2	○ 3	○ 4

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0=not at all true	1=rarely true	2=sometimes true	3=often true	4=almost always true

1. I felt sad or depressed	○ 0	○ 1	○ 2	○ 3	○ 4
2. I was not as interested in my usual activities.	○ 0	○ 1	○ 2	○ 3	○ 4
3. My appetite was poor and I didn't feel like eating.	○ 0	○ 1	○ 2	○ 3	○ 4
4. My appetite was much greater than usual.	○ 0	○ 1	○ 2	○ 3	○ 4
5. I had difficulty sleeping.	○ 0	○ 1	○ 2	○ 3	○ 4
6. I was sleeping too much.	○ 0	○ 1	○ 2	○ 3	○ 4
7. I felt very fidgety, making it difficult to sit still.	○ 0	○ 1	○ 2	○ 3	○ 4
8. I felt physically slowed down, like my body was stuck in mud.	○ 0	○ 1	○ 2	○ 3	○ 4
9. My energy level was low.	○ 0	○ 1	○ 2	○ 3	○ 4
10. I felt guilty.	○ 0	○ 1	○ 2	○ 3	○ 4
11. I thought I was a failure.	○ 0	○ 1	○ 2	○ 3	○ 4
12. I had problems concentrating.	○ 0	○ 1	○ 2	○ 3	○ 4
13. I had more difficulties making decisions than usual.	○ 0	○ 1	○ 2	○ 3	○ 4
14. I wished I was dead.	○ 0	○ 1	○ 2	○ 3	○ 4
15. I thought about killing myself.	○ 0	○ 1	○ 2	○ 3	○ 4
16. I thought that the future looked hopeless	○ 0	○ 1	○ 2	○ 3	○ 4

17. Overall, how much have symptoms of depression interfered with or caused difficulties in your life during the past week?

☐ 0= not at all ☐ 1= a little bit ☐ 2= a moderate amount ☐ 3= quite a bit ☐ 4= extremely

18. How would you rate your overall quality of life during the past week?

- ☐ 0) very good, my life could hardly be better
- ☐ 1) pretty good, most things are going well
- ☐ 2) the good and bad parts are about equal
- ☐ 3) pretty bad, most things are going poorly
- ☐ 4) very bad, my life could hardly be worse

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NOTICE OF PRIVACY PRACTICES

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

This Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information. As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each one of the following purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would be a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and revoke such authorization in writing and we are required to honor and abide by that written request, ext to the extent that we already have taken actions relying on your authorization.

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NOTICE OF PRIVACY PRACTICES

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, closer personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and account for disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 16, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures or our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201.
(202) 619-0257 Toll Free: 1-877-696-6775

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OFFICE POLICIES

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- It is your responsibility (and/or parent-guardian's) to cancel/reschedule an appointment.
- It is your responsibility (and/or parent-guardian's) to remember your appointment date and time. Reminder calls for appointments are a **COURTESY** provided by our office.
- It is your responsibility to request prescription refills 3 to 4 days prior to pick up.
- Patient management requiring phone calls, letters, review of records and other clinician time other than appointments are subject to a charge
- If arrangements are made for us to bill your insurance, managed care company, EAP or PPO, **You will be responsible for any co-payment or deductible required by your insurance plan and payment should be made at the time of service rendered.**
- In the event that your insurance coverage terminates or does not remit reimbursement during the course of treatment, payment for services becomes your responsibility and is required at the time of each visit.
- Please be advised that we only accept CASH, CHECK, or CREDIT CARD (Visa, MasterCard, Discover, and American Express) for payments.
- There is a **$25.00** charge for returned checks, plus the original amount of the check, plus additional bank charges
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