GHPA

Greater Houston Psychiatric Associates, PLLC

Patient Registration

Today's Date: _____

Patient Information

Patient's Legal Name _____

SS# _____ DOB _____ Age _____ Sex _____

Marital Status _____ DL # _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Employer/School _____ Occupation _____

Email _____ Alternate Phone _____

Emergency Contact _____

Relationship _____ Primary Phone _____ Secondary Phone _____

Referral Source _____

Medical History

Allergies _____

Medication _____

Current Physical Problems _____

Insurance Information

Name of insurance company _____ Phone _____

Address of Insurance Company _____

Name of insured _____ Relation to patient _____

Policy Number _____ Insured DOB _____ Sex _____

Employer _____

Second Insurance (if available)

Name of insurance company _____ Phone _____

Address of Insurance Company _____

Name of insured _____ Relation to patient _____

Policy Number _____ Insured DOB _____ Sex _____

Employer _____

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Patient Registration

Pharmacy Name _____

Address _____

Phone _____ Cross Streets _____

Responsible Party if Different than the Patient

Name _____

Address _____

Primary Phone _____ Secondary Phone _____

Authorization to Sign on Behalf of a Minor (if applicable)

I confirm that I am (please check one)

No legal documentation needed:

☐ The biological or adoptive parent having legal custody generally since birth, (i.e. not separated or divorced)

OR

The following must provide legal documentation

☐ The managing conservator; or

☐ Other legal guardian and have been granted guardianship by the court of biological parents.

Please describe type: _____

Advanced Directive

Do you have a Psych advance directive or power of attorney? ☐ Yes ☐ No

If yes, please provide a copy, if no skip.

Details: _____

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Assignment of Benefits

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider or GHPA for medical services.

Coordination of Benefits

In addition to your Primary Insurance coverage, are you, your spouse or dependent children covered by another group health insurance plan or Medicare?

☐ **Yes** *If yes, please complete the entire questionnaire below, sign and return to us.*

☐ **No** *If no, simply sign the form below and return to us.*

Please Print

Subscriber's Name: _____ Identification Number: _____

Subscriber's Social Security Number: _____Spouse's Social Security Number: _____

Other Health Insurance:

1. Are you, your spouse or your dependent covered under Medicare: ☐ YES ☐ NO
   If yes, please complete the following:
2. Name of person(s) covered: _____
3. Medicare #: _____
4. Is Medicare coverage due to disability caused by end stage renal disease? ☐ YES ☐ NO
5. Date of onset: _____ Date eligible for Medicare: _____
6. Do you have part A? ☐ YES ☐ NO
7. Do you have part B? ☐ YES ☐ NO

If other coverage exists, please fill out:

1. Policy Holder's Name: _____ Sex: ☐ Male ☐ Female

2. Policy Holder's Social Security Number: _____Date of Birth: _____

3. Name of Employer providing coverage: _____

4. Name of Other Insurance Company: _____Policy Number: _____

5. Address of Other Insurance Company: _____

   Phone Number: _____

6. Effective Date of Policy: _____Cancellation Date of Policy (If Applicable): _____

7. Policy Covers: Policy Holder Only _____ Two Persons _____ Family _____

I certify that the above information is correct

Signature**:** _____Date: _____

Patient's name: _____ DOB: _____

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Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. A copy of GHPA's Notice of Privacy Practices is also available on our website.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient

_____
Name of Personal Representative (if applicable)

_____
Description of Personal Representative's Authority

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Authorization for Use or Disclosure of Protected Health Information

Name of Individual: _____ **Date of Birth:** _____

I, the undersigned, authorize the following to disclose the above individual's protected health information:

Greater Houston Psychiatric Associates, PLLC 713-346-1555 713-346-1579

(Name of health care provider or entity authorized to disclose this information) (Phone) (Fax)

4888 Loop Central Dr., Ste #510 Houston, TX 77081

(Mailing Address)

TO: _____

(Name of person or entity who can receive and use this information) (Phone) (Fax)

_____

(Mailing Address)

Disclosure of information for the following purpose(s):

☐ Continued Care ☐ Legal ☐ Insurance ☐ Employment ☐ Education ☐ Personal Use

☐ Other: _____

Information to be disclosed: My medical records may include information regarding diagnosis and treatment of DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology) or PSYCHIATRIC DISORDERS. I understand that such information is confidential and is protected by federal law. HIPAA covered entities receiving this information are advised that federal regulation (42 CFR Part 2) prohibit their making any further disclosure without my written consent, or as otherwise permitted by such regulations. Information to be released includes:

☐Summary of treatment goals and progress ☐Treatment dates ☐Psychiatric evaluation ☐Psychosocial

☐Discharge and Aftercare Plan ☐Medication Record ☐Lab reports ☐Progress Notes ☐Treatment Plan

☐Demographic information ☐Complete Record ☐Other: _____

I ☐do ☐do not authorize this information to be disclosed electronically.

Effective Time Period: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; permission is withdrawn; 180 days following the date of the signature, or the following specific date (optional): Month_____ Day_____ Year _____

I understand that this authorization is voluntary and that treatment, payment, enrollment or eligibility for benefits cannot be conditioned on the signing of this authorization.

I understand that this authorization can be withdrawn by me at any time by giving written notice stating my intent to revoke this authorization to Greater Houston Psychiatric Associates. I cannot, however, take exception to actions that have taken place before I withdrew my authorization.

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations.

I understand that I have a right to have a copy of this signed form provided to me at the time of signature.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of heath information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including for the purposes of treatment, payment, or healthcare operations.

_____

(Signature of Individual or Individual's Legally Authorized Representative) (Date)

_____

(Printed Name of Legally Authorized Representative)

If representative, specify relationship to the individual: ☐Parent of minor ☐Legal Guardian ☐Other_____

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Authorization for Treatment

Patient Name: _____

I do voluntarily authorize such treatment involving routine diagnostic procedures and medical/psychotherapeutic treatment as considered appropriate by the patient's physician and /or therapist. I am aware that treatment often involves family therapy or family education. I understand that the physician or therapist will obtain my informed consent (or of parent or legal guardian) prior to treatment with any methods that are considered to include significant risk. I am aware that the practice of medicine/psychotherapy is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatments or examination to be rendered. I will be provided with a copy of the Patient Rights and Responsibilities upon request.

I also understand that all information disclosed within my session is confidential and will not be revealed to anyone outside of GHPA without written permission unless required by law or necessary to comply with the requirements of insurance agencies. Disclosure may be required by laws if: (1) there is a reasonable suspicion of abuse/neglect to a child/teen, dependent or elder adult; (2) the client communicates a threat of bodily injury to self or others or (3) disclosure is required pursuant to a legal proceeding.

Patient's signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(By my signature, I certify that I am the parent or legal guardian of this child and my power to consent to treatment has not been removed or limited).

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Notice of Operational Procedures

Dear Patient,

Greater Houston Psychiatric Associates (GHPA) providers are dedicated to providing quality medical care and excellent service. Please review the following operational policies and procedures as they apply to your treatment.

PROTECTED HEALTH INFORMATION
The federal Health Insurance Portability and Accountability Act (HIPAA) requires written signature for specific authorization to inspect, copy, forward or release your protected health information for purposes other than treatment, payment, and healthcare operations. GHPA will not release your protected health information without your signed Authorization for Use or Disclosure. We request periodic updates of health history, insurance, and demographic information (address, phone number, emergency contact, etc.). Accurate information will assist us in providing quality care, maintaining appropriate contact with you, and process your claims properly.

PRESCRIPTION REFILLS
Please request refills from your pharmacy, as this will increase timely response. Also, please ensure that you are referencing your most recent prescriptions when asking for refills. Refills might be denied if you are overdue for your appointment. It is your responsibility to ensure that you allow sufficient time for refill requests to be processed. It typically takes 2 business days for a refill to be processed. There may be a charge for controlled substance refills if requested at a time outside of a physician visit. Your provider will inform you if there will be a charge and the fee amount.

FINANCIAL POLICY
GHPA is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. We file insurance claims as a courtesy for our patients. It is every patient's responsibility to understand their insurance policy and benefits. Payment is due at the time of service. Payment includes co-payments, deductibles, and co-insurance. If your insurance carrier denies payment because of benefit limitations or non-covered services, you will be responsible for the charges. If your insurance carrier needs additional information, you are responsible for providing it to them.

PAYMENT FOR NON-CLINICAL SERVICES
Insurance carriers do not cover forensic services, child custody evaluations, preparation of disability or written reports, or the copying of medical records. Also, insurance carriers do not cover fees and costs associated with court ordered medical records, testimony, or personal court appearance regarding your treatment. Payment of these services are your responsibility

CANCELLATIONS
Twenty-four-hour notice is required for appointment cancellations. Your provider may assess a fee if sufficient notice is not given or if you miss an appointment. Insurance carriers do not cover this charge.

RETURNED CHECKS
There is a service charge for returned checks.

DELINQUENT ACCOUNTS
Your account may be released to a collection agency if it becomes delinquent. You will be responsible for any collection agency fees.

I acknowledge receipt, understanding, and acceptance of these policies

Signature of patient (or guardian if patient is a minor): _____

Date: _____

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Patient Rights and Responsibilities

- Patients have the right to be treated with personal dignity and respect.
- Patients have the right to care that is considerate and respects patient's personal values and belief system.
- Patients have the right to personal privacy and confidentiality of information.
- Patients have the right to receive information about managed care company services, practitioner, clinical guidelines, and patient rights and responsibilities.
- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Patients have the right to participate in an informed way in the decision-making process regarding treatment planning.
- Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost or benefit coverage.
- Patients have the right to individualized treatment including:
  Adequate and humane services, regardless of the source of financial support
  Provision of services in the least restrictive environment possible
  An individualized treatment plan
  Periodic review of the treatment or program plan
  An adequate number of component, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan
- Patients have the right to participate in the consideration of ethical issues that arise in the provision of care and services including:
  Resolving conflict
  Withholding resuscitative devices
  Forgoing or withdrawing life-sustaining treatment
  Participating in investigational studies or clinical trials
- Patients have the right to designate a surrogate decision-maker if the patient is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- Patients and their families have the right to be informed of their rights in a language they understand.
- Patients have the right to voice complaints or appeals about the managed care company or care provider.
- Patients have the right to make recommendations regarding managed care company rights and responsibilities.
- Patients have the right to be informed of rules and regulations concerning patients' conduct.
- Patients have the responsibility to give their provider and managed care company information needed in order to receive care.
- Patients have the responsibility to follow their agreed-upon treatment plan and instructions for care.
- Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with their provider mutually agreed-upon treatment goals.

Signature: _____ Date:_____

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Release of Information for Primary Care Physician

The physicians and therapists of ***Greater Houston Psychiatric Associates*** may need to release limited diagnostic and treatment plan information to your primary care physician and other referring professionals. This communication promotes coordination of treatment and is at all times necessary for the authorization of payment by third party payers.

To assist us in identifying the parties requiring this information, we ask that you identify the following;

Primary Care Physician name: _____

Check one: Pediatrician ___ Family Practice ___ General Practice ___

Internist ___ OB/GYN ___ Other: _____

Address: _____ City, State, Zip: _____
(if exact address is not known, please provide clinic and/or street name)

Phone: _____ Fax: _____

If you were referred by an Employee Assistance Program:

EAP Name: _____

Referring Staff member: _____

Address: _____City, State, Zip _____

Phone: _____Fax:_____

If you were referred by another professional to whom you wish us to send information:

Name: _____Organization: _____

Address: _____ City, State, Zip: _____

Phone: _____Fax: _____

I authorize Greater Houston Psychiatric Associates to communicate assessment and recommendations to the professional (if any) who referred me. I further understand and agree that if I am using insurance, certain information regarding diagnosis and treatment will be released to the insurance company. I authorize release of information necessary to coordinate and/or authorize my treatment.

Patient's printed name: _____ DOB: _____

Patients Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**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
Add the score for each column				

Total Score (add your column scores): _____

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

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

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying.	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things.	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing.	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still.	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable.	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

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

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

CAGE Adapted to Include Drugs (CAGE-AID)

Patient Name: _____ **Date:** _____

Please circle "yes" or "no" for each question.

Have you felt you ought to cut down on your drinking or drug use?	Yes ☐	No ☐
Have people annoyed you by criticizing your drinking or drug use?	Yes ☐	No ☐
Have you felt bad or guilty about your drinking or drug use?	Yes ☐	No ☐
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	Yes ☐	No ☐

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Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Greater Houston Psychiatric Associates.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____	_____
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
_____	_____
Patient Printed Name	Date