Dr. Garb Dr. Brown Dr. Peterson Dr. Gillaspie Dr. McReynolds Dr. Thomas

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient/Guarantor Name:_____

Doctor:_____ 1St Date of Treatment:_____

By signing this form, you acknowledge that above named doctor has given you an opportunity to read their Privacy Notice, which explains how your health information will be handled in various situations. Should you need a copy, please request from receptionist. We must try to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging this notice as soon as we can after the emergency.

By your signature below, you are asserting that:

I have read above named doctor's Privacy Notice.

I have been given the chance to discuss my concerns and questions about the privacy of my health information.

_____

Patient's Signature / Guarantor Signature Date

MPA staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice?

   [ ] Yes [ ] No

2. Please explain why the patient was unable to sign an acknowledgement form and the doctors efforts in trying to obtain the patient's signature:_____

_____

_____

_____

_____

_____

Karen S. Brown, M.D.
Ronald Garb, M.D.
Aaron M. Peterson, D.O.

Cassidy A. Gillaspie, M.D.
Edwards U. McReynolds, M.D.
Patrick S. Thomas, M.D., Ph.D.

General Psychiatry Diplomates, American Board of Psychiatry & Neurology

929 Gessner · Suite 2000 · Houston, Texas 77024 · 713-973-1007 · 713-973-0104 fax

OFFICE CANCELLATION POLICY

As a courtesy, we try to give you a call/text before your appointment. If you own a cellular telephone, we suggest placing a reminder into the calendar feature normally available. But your appointment is ultimately your responsibility.

When canceling an appointment, 24 hours notice is required. You may cancel by calling our office, by texting, or leaving a message on our voicemail.

If you fail to cancel your appointment before 24 hours, you will be billed for the full fee-for-service amount of the visit.

I have read, understand and agree to this policy.

_____ _____

Signature Date

Karen S. Brown, M.D.
Ronald Garb, M.D.
Aaron M. Peterson, D.O.

Cassidy A. Gillaspie, M.D.
Edwards U. McReynolds, M.D.
Patrick S. Thomas, M.D., Ph.D.

General Psychiatry Diplomates, American Board of Psychiatry & Neurology

929 Gessner · Suite 2000 · Houston, Texas 77024 · 713-973-1007 · 713-973-0104 fax

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal treatment needed for your health. In order to serve you better, we require that all patients read and sign our financial policy as well as complete our patient information prior to seeing the doctor. If you have any questions, please do not hesitate to ask.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, debit, Visa, MasterCard, Discover and American Express. We will be happy to process your insurance claim for reimbursement as long as your benefits have been verified, your visit is properly pre-certified and we are an in-network provider.

Please understand:

1. Your insurance card must be brought with you to each visit so we may keep up to date on any policy changes. Your insurance policy is a contract between you, your employer and the insurance company. Please inform us at least 2 days in advance of your appointment if there have been any changes to your coverage so that we may verify benefits with your insurance company. If we are unable to obtain verification before your appointment, you will be responsible for the entire fee-for-service amount of the visit.
2. All charges are ultimately your responsibility, whether your insurance pays for the visit or not. Fees for non-covered services, deductibles and co-payments are due at the time of the visit.
3. Returned checks and/or stop payments will incur a service charge.
4. Please note that unless cancelled 24 hours in advance, you will be charged for missed appointments at the fee-for-service amount.
5. There is a charge for copying and releasing medical records. We need a signed authorization form from the patient or legal guardian detailing where the records are to be sent and payment is due in advance. Please allow enough time to have these records received.
6. Letters written and forms completed by the physician will incur a fee. The fee varies by request and is payable when forms/letters are requested.
7. **All** prescription refill and/or new requests require 48 hours turn-around time. Please plan accordingly. Please remember all schedule II (controlled substance) prescriptions must be filled within 21 days of date written or they will expire.
8. All prior authorizations for medications required by your insurance company will incur a fee, whether approved or denied.

I have read, understand and agree to this policy.

_____ _____

Signature Date

Karen S. Brown, M.D.
Ronald Garb, M.D.
Aaron M. Peterson, D.O.

Cassidy A. Gillaspie, M.D.
Edwards U. McReynolds, M.D.
Patrick S. Thomas, M.D., Ph.D.

General Psychiatry Diplomates, American Board of Psychiatry & Neurology

929 Gessner, Suite 2000
Houston, Texas 77024
713-973-1007
713-973-0104 fax

Financial Agreement Notice

Verification of your insurance is not a guarantee of payment. Amounts due by you (the patient/guarantor), are based on what has been quoted to us via fax, phone or on-line services, and is not necessarily your entire balance. Your insurance company determines payment, according to the policy you have chosen and the contract your employer has with them, when the claim is received. Every effort is made by this office to submit accurate information to your insurance company so maximum payment will be made per your policy. If this office makes an error in submission, we will make corrections and resubmit claims to your insurance, however, we have no control over how claims are paid or how payment is determined.

The patient/guarantor is responsible for payment of any balances left after the insurance pays their part and all contract adjustments are made. The patient/guarantor is responsible for balances due to claims not paid by the insurance company within 45 days of submission.

If we file your claim and the insurance company sends payment to you in error, it is your responsibility to make sure the check reaches our office. Your insurance company should not be sending you any payments for expenses not paid by you.

If you do not agree with the way your insurance company has paid your claim, if you have any questions regarding claim payment, or payment has not been made, please contact your insurance company for explanation. Existing balances on your account must be paid in full prior to receiving additional services even if you are appealing or questioning claims payment. If additional payment is received causing a credit on your account a refund will be made to you.

I have read, understand and agree to this policy.

_____ _____

Patient Name Date

_____

Signature of Patient or Guarantor

CONFIDENTIAL HISTORY / PRE-REGISTRATION

Date_____ Doctor you are seeing today?_____

Patient Information

Last_____First_____MI____DOB_____

Sex: M F Marital Status_____ SSN_____ TDL#_____

Patient's Address_____

_____Zip_____

Home #_____ Work #_____ Cell #_____

Employer_____ Referred by_____

If patient is a minor please complete the following:

Mother's Last_____First_____MI____DOB_____

Father's Last_____First_____MI____DOB_____

Who does the child live with?_____Are parents: ☐ living together ☐ not living together

Legal Guardian _____
(please provide copy of court order)

Guardian's Address_____

_____Zip_____

Patient History

Have you had previous psychiatric treatment? ☐ Yes ☐ No

Name and phone number of practitioner_____

Date last seen_____ May we contact your last practitioner ☐ Yes * ☐ No

(* If yes, please complete Authorization for Release of Medical Information so we may obtain records)

Are you currently under the care of a primary care physician? ☐ Yes ☐ No

* If yes, for what diagnosis_____

Name and phone number of physician_____

Hospitalizations:

Give the following information on previous hospitalizations (Women: Do not list normal pregnancies or child birth):

	Hospitalization (1)	Hospitalization (2)	Hospitalization (3)
Reason for Hospitalization			
Month and year hospitalized			
Name of Hospital City & State			

Habits:

Tobacco: ☐ Cigarettes ____Packs per day ☐ Caffeine (coffee, tea, soda) _____# per day

Alcoholic Beverages: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily _____# per day

Illicit Drugs: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily _____# per day

Have you ever been treated for alcoholism? ☐ No ☐ Yes **When?**_____

Have you ever been treated for a drug problem? ☐ No ☐ Yes **When?**_____

Medications:

Name all medications you take on a regular basis. (Example: Sedatives, tranquilizers, sleep aids, appetite suppressants, hormone tablets, diabetic medications, birth control pills, pain relievers, etc.)

_____

_____

_____

Name all psychiatric medications that you have taken in the past, date taken, and reason you are no longer taking:_____

_____

_____

Concerns

Weight now?_____ **Weight one year ago?**_____ **Maximum weight and date**_____

Any problems or changes with the following: (Circle all that apply)

Sleep **Sex** **Appetite** **Maintaining Social Activity**

Family psychiatric history:

	Diagnosis	Age of Onset	Treatment
Children			
Father			
Mother			
Brothers/Sisters			

Reason for visit

Please give a brief explanation of why you are seeking psychiatric help at this time:

_____

_____

_____

Date_____ **Signature & Relationship to patient**_____

Karen S. Brown, M.D.
Ronald Garb, M.D.
Aaron M. Peterson, D.O.

Cassidy A. Gillaspie, M.D.
Edwards U. McReynolds, M.D.
Patrick S. Thomas, M.D., Ph.D.

General Psychiatry Diplomates, American Board of Psychiatry & Neurology

929 Gessner · Suite 2000 · Houston, Texas 77024 · 713-973-1007 · 713-973-0104 fax

Assignment And Release

I, the undersigned, have insurance coverage with _____ and assign directly to above physician(s) all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the use of this signature on all my insurance submissions.

_____ Date_____
Signature of Insured or Legal Guardian (circle one)

Treatment Authorization

I authorize above physician(s) to give me reasonable and proper medical care by today's standards.

_____ Date_____
Signature of Patient or Legal Guardian (circle one)

Responsible Party Agreement

I,_____, guarantor of this account, agree to pay the balance due. Should the collections department need to contact me in regards to this account and are unable to reach me by mail or home phone, then I may be reached at my work number.

_____ Date_____
Signature of Guarantor

Karen S. Brown, M.D.
Ronald Garb, M.D.
Aaron M Peterson, D.O.

Edwards U. McReynolds, M.D
Cassidy A. Gillaspie, M.D.
Patrick S. Thomas, M.D., PhD

929 Gessner, Suite 2000 · Houston, Texas 77024 · 713-973-1007 · 713-973-0104 fax

Authorization for Release of Information From Medical Record
(one request per page)

Patient Name_____ DOB_____

I hereby authorize the following provider: (circle one)
Karen Brown Ronald Garb Aaron Peterson Cassidy Gillaspie Edwards McReynolds Patrick Thomas

□ to **obtain** the following from:_____phone/fax_____/_____
□ Progress notes (initial visit plus last 3 visits) □ Laboratory Reports □ Verbal Communication
□ Other (please specify)_____

OR

□ to **release** the following to:_____phone/fax_____/_____
□ Progress notes (initial visit plus last 3 visits) □ Laboratory Reports □ Verbal Communication
□ Other (please specify)_____

I understand and agree that the information I am authorizing to be released may include mental health information; HIV/AIDS test results, diagnosis, treatment and related information; or drug test results and information about substance use and treatment.

I further understand that I may revoke or cancel this authorization at any time by notifying the Doctor's office in writing, except to the action has been taken in reliance on it. Unless earlier revocation, this authorization automatically expires in 365 days after date of request unless another date, event or condition is specified.

To the Party receiving this information
This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains. A general authorization for Release of Medical Information is not sufficient for this purpose.

I release and agree to hold above named physicians and their agents, employees and representatives harmless from all liability associated with the release of confidential patient information. I understand that the above named physicians cannot be responsible for the use of redisclosure by a third party.

_____ _____
Patient/Guardian Signature Witness

_____ _____
Print Name Print Name

_____ _____
Date (valid for 365 days unless otherwise specified) Date

PHARMACY INFORMATION

****ALL fields MUST be filled out for your meds to be sent**

PATIENT NAME: _____

PHARMACY NAME: _____

PHARMACY PHONE #: _____

PHARMACY ADDRESS: _____