NEW PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ □ M □ F

Local Address: _____ City:_____Zip:_____

Mailing address (if different): _____City:_____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Agree being contacted via email? □ Y □ N Via Text? □ Y □ N

Agree to receive appointment reminders at listed email? □ Y □ N Agree to voice messages at: □ Home □ Cell

□ Single □ Married □ Divorced □ Separated □ Widowed Who referred you to us?_____

PROVIDERS:

Primary Care Physician Name and Tel: _____

Counselor Name and Tel: _____

Previous Psychiatrist Name and Tel: _____

Name / Address of your Pharmacy: _____

FINANCIAL / INSURANCE INFORMATION:

Insurance: _____ Policy Holder: _____ Date of Birth: _____

Group # _____ Member ID: _____ Deductible renewal date: _____

RxBIN_____ RxPCN_____ RxGROUP_____

Address of policy holder (if different): _____ City/Zip:_____

Person responsible for financial matters and release to be contacted if needed: _____

EMERGENCY CONTACT: *For safety reasons, please provide information. Do not leave blank*

Name: _____ Relationship: _____ Tel: _____
Address: _____ Consent to Release Information: _____

Name: _____ Relationship: _____ Tel: _____
Address: _____ Consent to Release Information: _____

INTAKE INFORMATION

Presenting problem and concerns: _____

- ☐ Depression/Sadness
- ☐ Crying spells
- ☐ Fatigue/Low energy
- ☐ No pleasure
- ☐ Hopelessness
- ☐ Guilt/Shame
- ☐ Low interest/motivation
- ☐ Isolation
- ☐ Poor concentration/focus

- ☐ Poor memory
- ☐ Changes in sleep
- ☐ Changes in appetite
- ☐ Past thoughts of suicide
- ☐ Present thoughts of suicide
- ☐ Thoughts of harming others
- ☐ Self-injury behaviors
- ☐ Eating problems
- ☐ Hearing voices/seeing visions
- ☐ Paranoia/Suspiciousness
- ☐ Anger/Irritability
- ☐ Mood swings
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Phobias/Fears
- ☐ Obsessions/compulsions
- ☐ Social discomfort
- ☐ Trauma/flashbacks/nightmares
- ☐ Alcohol/Drug use
- ☐ Other _____

Past History:

- ☐ Suicide attempts
- ☐ Violence toward others
- ☐ Self-Injury
- ☐ Psychiatric Hospitalizations
- ☐ Drug/Alcohol Treatment
- ☐ Previous Psychiatric Diagnosis
- ☐ Counseling

Past Medication Trials and response/side effects:

Current Medications and Dose (include non-psychiatric medications and over the counter/supplements****)**:

Medical Conditions: _____

- ☐ Seizures
- ☐ Head trauma
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Chronic Pain

Allergies: _____ **Surgeries**: _____

Date of Last Physical Exam/ Bloodwork: _____

Substance Use:

	Current Use	Past use	Last time used	Amount of current use	Frequency of current use	Withdrawals?
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Cocaine/Crack						
Heroin/Opiates						
Prescription pills						
Ecstasy						
Inhalants						
Methamphetamines						
PCP/LSD						

Legal History:

- ☐ DUI/DWI
- ☐ Assault
- ☐ Possession of substances

☐ Custody ☐ Truancy ☐ Parole or probation

Family Psychiatric History: **Relationship to patient**

Depression	
Bipolar	
Anxiety/Panic Attacks	
ADD/ADHD	
Substance abuse	
Schizophrenia/Psychosis	
Suicide	

Current Stressors:

☐ Relationships ☐ Job/School ☐ Legal
☐ Home ☐ Financial ☐ Marital

Trauma or Abuse History:

☐ Physical ☐ Sexual ☐ Parent illness or death
☐ Emotional ☐ Crime ☐ Homelessness
☐ Neglect ☐ Combat

How would you describe your childhood?

☐ Happy ☐ Uneventful ☐ Traumatic
☐ Good ☐ Tough

Support System: _____ **Strengths/Hobbies**: _____

Occupation: _____ **Education/Highest level**: _____

CONSENT FOR TREATMENT

By your signature below, you acknowledge that you are presenting yourself to Dorian Aponte, M.D /iChange Counseling and Psychiatry for evaluation, diagnosis, and/or treatment of a medical or psychiatric condition. You give consent and authorize Dr. Aponte or her designees to order and/or perform all exams, tests, procedures, and any other care deemed necessary or advisable for the evaluation, diagnosis, and treatment of this medical condition. This consent is valid for each visit made to the office, unless and until revoked in writing.

By your signature, you acknowledge that you have read and understand the information obtained in this consent and the policies and procedures. You accept the terms of this consent and the policies and procedures of the office. Please keep a copy of these policies and procedures for your records.

CHILD/ADOLESCENT CONSENT FOR TREATMENT

I certify that I am the ( ) father, ( ) mother, ( ) legal guardian and have legal custody of the above named patient. I, hereby, give my authorization and consent for the patient to receive outpatient evaluation and treatment from Dr. Aponte. I understand that the legal guardian or parent bringing the patient for treatment is responsible for payment at the time of service, regardless of any financial arrangement for payment of the patient's care, either oral or written, with the patient's other parent or responsible party. I also understand that treatment and recommendations will be discussed with the parent present during the visit and it is the responsibility of that parent to communicate the information to the other parent.

Name / Signature: _____ Date:_____

Office Policies and Procedures

This document is intended to inform you of our office policies, procedures, state / federal laws, and your rights.

The Initial Psychiatric Visit: Your initial visit will be 45-50 minutes long and will include an evaluation and treatment plan/recommendations. Please be aware that the initial visit is for consultation only and does not necessarily imply a long-term treatment relationship or that medications will be prescribed. It is important for doctor and patient to meet and mutually agree to continued care. If the doctor determine that she is unable to assist you or that your needs fall outside of the scope of the practice, attempts will be made to refer you to someone who can. If you no show to the intake appointment but wish to reschedule, full payment of the visit plus a no show fee is required prior to rescheduling.

Follow up visits: Follow up visits will be necessary to evaluate your response to treatment as well as to continue to monitor your symptoms. **They generally last 20 minutes**. The frequency of these visits will be decided upon by your current status, care needs, and type or treatment provided (ex: monthly controlled substance prescriptions). Any patient suspected to be intoxicated with any substances during a visit with the provider will not receive treatment. **Private pay fees are determined by several factors, including but not limited to: length of appointment, crisis support and complexity of session.**

No Show/Late Cancellations/Missed or Rescheduled Visits: Our business hours are Monday to Thursday 9:00am-4:00pm, Friday 10:00am-3:00pm. Dr. Aponte reserves your appointment time only for you (i.e., does not double book patients). If you are unable to come to your appointment, please give at least **24 business hours' notice** (weekends are not considered business days). If you provide less than 24 hours' notice (or no notice), you will be charged a **$60 fee** and payment is expected prior to your next visit.

If you have missed 5 or more minutes of your appointment time, the appointment may need to be rescheduled and it will be considered a "no show" visit and carry a **$60 fee**. If you cancel late or no show for your visits more than once, we reserve the right not to reschedule your appointment.

Dr. Aponte respects your time and makes it a goal to always be on time for your appointment. That said, occasionally an emergency with another patient could cause her to be delayed, but this will be rare. An attempt to contact you will be made if we are aware there may be a delay in your appointment.

Appointment Reminders: Reminder emails for appointments are placed as a courtesy. These emails are not mandatory and not receiving a reminder does not mean you no longer have an appointment. You will still be responsible for any fees incurred for missing a visit or not cancelling with 24 business hours' notice. In order to avoid reminder emails from going into your spam folder instead of your inbox you should add **appointment@practicefusion.com** to your list of authorized emails.

Services not provided:

- Specific substance abuse treatments, such as methadone or suboxone.
- Inpatient treatment (Dr. Aponte does not hold admitting privileges at any of the local hospitals).
- Treatment with injectable medications.
- **Disability determinations** (**short term or long term disability, FMLA leave from work, or social security disability**).
    - **Court appearances / legal letters of medical opinions**: If a subpoena were to occur and the doctor or staff needs to appear in court, the patient will be responsible for payment of applicable fees, which may include: $400 physician hourly fee, $55 staff hourly fee, applicable charges for medical records copies/staff hourly preparation fee, $65 for preparation of subpoenaed records, and **all legal fees** incurred by the physician, staff or practice for the purpose of complying with the court subpoena or record request. Expedited requests for records will carry an additional fee of $25.

Payment and Fees: Payment is expected at the time of service. The office accepts **cash and checks** at this time. For your convenience, there is an ATM in the gas station near us, if you need to get cash for your payment. We only accept credit cards for charges over $100. There is a $35 fee for returned checks.

Insurance Notice: Dr. Aponte is only under contract with **Blue Cross Blue Shield (BCBS) PPO**. She is considered an "out-of-network" provider for all other insurances, including other types of BCBS (ex: HMO) and those who subcontract Mental Health benefits out to other insurance companies. BCBS does not provide a reliable way for practices to verify this information beforehand so patients are responsible for calling their insurance to verify mental health benefits. If BCBS denies payment for any reason (including, but not limited to, services are not covered under your policy or are subcontracted to a third party), you will be responsible for the full price of your visit. If you will be filing insurance for out of network benefits, we will provide you with an invoice that contains all the necessary information. It is your responsibility to contact your insurance company to establish what you will be reimbursed. Please contact your insurance company to verify if you will need prior authorization for your visits with the physician.

In the event that an account is 30+ days overdue and turned over to our collection agency, the patient or responsible party will be held responsible for any collection fees charged to our office to collect the debt owed plus a $50 fee. If your account has a credit, we will refund you once written notification is received. Unclaimed credits are forfeited after one year of last service date. If payment is not received as arranged, we reserve the right to contact the parties involved in the collection of payment. **If we issue a reimbursement, you have 30 business days from the date of the check to deposit.**

Changes in Fees: Visit costs may change throughout the year secondary to updates in insurance fees/coverage/ deductibles (if you carry insurance) or the services provided by the doctor during your visit, which may vary each time. **We reserve the right to adjust the non-insurance fees schedule and will provide adequate notice in a visible location in office prior to changes taking effect.**

Credit Cards: If a credit card is used to pay fees over $100 or to pay for services over the phone, I authorize Dr. Aponte's office staff to collect my information and process the payment. This information will not be used or stored without my permission. Signature: _____ Date: _____

Prescription Refill Requests: You should be aware of the amount of medication you have left and when you will need a refill. The doctor will prescribe enough medication to last until your next appointment. If you miss an appointment, it is your responsibility to request a refill so that you do not run out of medication. The doctor may refuse to give a refill if she has not seen you recently and feels that an office appointment is clinically indicated. To request a refill, please contact your pharmacy first and they will send the electronic request. Please be aware certain classes of medication cannot be refilled electronically and will require paper prescriptions (i.e. ADD/ADHD medications). Please allow 48-72 business hours to process refill requests. Refills are not processed over the weekend or holidays.

Insurance companies will sometimes request a Prior Authorization (PA) before approving your medication. Please allow 48 business hours for the PA to be completed by the doctor. This however does not mean that the PA will be approved within 48 business hours; that is determined by the insurance company.

Communicating with the practice: We do our best to always be available to take your call during regular business hours. We are a small practice and do not hold business hours during evenings, weekends, or holidays. In the event you get our voicemail during business hours and you choose to leave a message with your information, a member of our staff will call you back promptly. After hours messages will be answered the next business day. Phone calls with the doctor lasting longer than 10 minutes are billable at a rate of $2.00 per minute.

Email/Texting policy: Email communication is convenient and helps reduce "phone tag". That said, confidentiality/encryption via electronic communications cannot be guaranteed. Keep this in mind when sending sensitive information via email. The office is not responsible for any security breach although we make every attempt at protecting your confidentiality. If you initiate communication with the practice via email, we will take this as an implied consent for exchange of sensitive information via email. Email communications with the office are not monitored in real time and as such, emergencies should be communicated via phone to the office during regular business hours. Dr. Aponte does not communicate with patients via text due to confidentiality and safety.

Emergencies: We will work together to help ensure your safety. We are not a crisis facility. If you are having a crisis or emergency after business hours please call 911 or go to your nearest emergency room. You may also reach the Crisis

Team at MHMR at 800-762-0157 to speak with an emergency provider after hours and this is accessible through our office line after business hours.

Vacations and Holidays: As a solo practitioner, Dr. Aponte will have limited coverage during vacations and holidays. Vacation times will be announced with enough time so that you can plan ahead for your appointment, refill requests, etc.

Audio or Video Recording: Audio and video recording are **strictly prohibited** in the practice. Dr. Aponte will not record patient sessions and she does not consent to the recording of any of the sessions. This violates her privacy and confidentiality. Please refrain from this practice.

Safety: Weapons of any kinds, with or without license to carry, are **strictly prohibited** in our premises.

Medical Record Requests, Letter and Forms: Medical record requests require a "Release of Information Form" signed by the patient in its entirety. Records are sent directly from Dr. Aponte's office to the requesting physician's office. Medical records requested for the patient's own use carry a charge (35 cents per page, $55 per hour clerical fee) and may be provided in the form of a treatment summary at the discretion of the physician. Letters and completion of forms may carry a charge. Expedited requests for records will carry an additional fee of $25.

Certification letters for **emotional support pets or service animals** will not be written without receiving proper documentation of training / evaluation done to certify the animal has been trained for such purpose.

By signing below, you give consent to iChange and its providers to be custodian of your file and to access it for you if Dr. Aponte were to become incapacitated or die. You also give consent for staff to contact you via telephone or email in case of such events..

I understand that my care will be considered inactive/terminated if I have not been seen in the clinic for nine (9) or more months. At that point Dr. Aponte will no longer be considered my physician of record.

HIPAA NOTICE OF PRIVACY PRACTICES

The federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 C.F.R. parts 160 and 164).This form documents that Dr. Dorian Aponte has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment, and health care operations. PHI is information in your health record that could identify you.

Each time you visit the office, a record of your visit is made. This record contains your symptoms, diagnosis, treatment and plan for future care or treatment. It serves as the basis for planning your care and treatment. However, it also can act as a legal document describing the care you received and as a means by which you or a third-party payer can verify that the services billed were actually provided. It may also be a means of communicating with other health professionals who contribute to your care.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand, who, what, when, where and why others may access your health information, and make more informed decisions when authorizing release to others.

Your Health Information rights:

- Although your record is the physical property of Dr. Aponte, the information belongs to you. You have the right to:
- Request restriction on certain uses of your information
- Obtain a paper copy of the Notice of Privacy Practices
- Amend your health record according to legal protocol
- Request communications of your health information by alternative means
- Revoke your authorization to use your health information except to the extent that action has already been taken or is required by law.

Our Responsibility:

- Maintain the privacy of your health information
- Provide you with a notice as to my legal duties and privacy practices with respect to the information I collect about you
- Abide by the terms of this notice

- Accommodate reasonable requests you may have to communicate health information by alternative means
- I will not use or disclose your health information without your authorization, except as described in this notice.

Inspections or Copies of Health Information: You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons: the information is psychotherapy notes, the information reveals the identity of a person who provided information under a promise of confidentiality, the information is subject to the Clinical Laboratory Improvements Amendments of 1988, or the information has been compiled in anticipation of litigation. Additionally, if the information in the record could cause mental harm to you, a summary will be provided instead.

Amendment of Medical Information: You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the practice. We will respond within 60 days of your request if able. We may refuse to allow an amendment for the following reasons: the information wasn't created by this practice or the physician in this practice, the information is not part of the designated record set, the information is not available for inspection because of an appropriate denial, or the information is accurate and complete. Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Examples of Disclosures for Treatment, Payment and Health Operations: Dr. Aponte will use your health information to provide treatment. With your permission she will share this information with your other doctors or family members. If a third party payer is paying for the bill, then they will get information that identifies you, as well as your diagnosis and the type of treatment provided. Please note the practice utilizes electronic medical record systems and others as part of the routine operation of the practice (this includes but is not limited to Practice Fusion, Availity, Google, Square or QuickBooks) In addition, Dr. Aponte may be required to disclose health information for law enforcement purposes, or in response to a valid subpoena, or in relationship to a workers' compensation claim. She will make every effort to inform you if such a request is made.

Your safety is Dr. Aponte's highest priority. Other medical providers (for example, a therapist), family members, friends, landlord, neighbors, your place of employment, or police may be notified if there is significant concern for your safety or the safety of others. If feasible, Dr. Aponte will attempt to get your permission, but this can be done without your permission or even if you protest, if your safety is at risk. The fewest number of people will be notified in order to ensure your safety (i.e., your place of employment or neighbors would be notified only if their notification would be of immediate benefit to you or someone else).

Other Disclosures Required by Law: Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

Complaints, Contact for Requests or Records, and Grievance Policy: iChange Counseling and Psychiatry and its providers are committed to providing the highest quality of services to all clients. If a person receiving services is not satisfied with the services being provided or experiences a situation that cannot be resolved satisfactorily between themselves and the doctor or staff member, he or she will be provided the opportunity to initiate a grievance with Dr. Aponte/iChange Counseling and Psychiatry or its designees and the Texas Department of Human Services (DHS) to further assist him or her in resolving the matter. Each step of the outlined procedure should be carried out within a timely manner. In addition to an oral conference throughout this process, the client shall submit in writing a statement of the grievance issue to Dr. Aponte/iChange Counseling and Psychiatry designee.

Grievance Procedure: Discuss the matter with the doctor, staff, or representative of the private practice to seek a satisfactory resolution, which may include referral. In the event that a satisfactory resolution cannot be achieved, the client reserves the right to file a grievance with the Texas Department of State Health. The information below is provided in the event the client finds it necessary to file a grievance with the Texas Department of Health and Human Services and/or the licensing board.

Texas Department of Health and Human Services, 701 W. 51st Street, Austin, Texas 78751 512-438-3011

Texas Medical Board, 333 Guadalupe, Tower 3, Suite 610, PO Box 2810, MC263 Austin, TX 78768-2018 1-80-201-9353

I have read and acknowledge the above information regarding privacy and office policies and understand my responsibilities.

_____ _____

Patient Signature/Date **Witness Signature/Date**

___ I have reviewed the **HIPAA policy** and **Consent Form**. I am aware that I may view these on the practice website or in person. I understand I may take a copy home. I am aware of the **service fee schedule**. I understand 3rd party vendors such as, but not limited to Google, Gmail, Practice Fusion, Square, Quickbooks and Availity may be used. Some of these programs may have access to your information, including your email and may send you receipts and other account information.

___ I am aware that **my insurance may request diagnoses, coding, and other private information** and that the practice will need to release this information for payment. I am aware **insurance may not pay** for all services rendered and that I am **100% liable** for any amount the insurance does not pay. I have read and understand the insurance policy listed on the intake paperwork. *You have one year to request credits, after one year the credit will be voided.* **If a reimbursement check is issued, you have 30 business days to deposit.**

___ I am aware there is a $60 fee for **no show visits and for appointments cancelled with less than 24 business hours' notice**. Saturday, Sunday and Holidays are not business days.

___ I am aware that payment is due for all services rendered at the time of the appointment. I agree to pay any **outstanding balances**, attached fees for **late payments ($25), bounced checks ($35), and no show / late cancel fee ($60). Private pay rates have changed, fees will now be determined by length and complexity of session.**

___ In case a payment is made over the phone, I agree to my **credit card** information being collected, entered, and processed. Signature: _____

___I consent to using my electronic signature.

___I understand that proper follow up is required for **medications** to be prescribed. I also understand that prescriptions need to be requested 48 business hours in advance before they are due to ensure our office and the pharmacy has enough time to process your request.

___ I agree to communication via the means listed and initialed below although encryption cannot be guaranteed

_____ Text
_____ email
_____ voicemail.

___ I am aware and understand that weapons of any kind, with or without license to carry, are strictly prohibited in our premises. We do enforce penal codes 30.06-30.07. Video or audio recording of sessions is also prohibited.

___ I understand the members of the office staff have associate agreements to protect your privacy and abide by the privacy act and do not share your confidential information. **This also applies to any other business in our joined suite.**

___I understand that my care will be considered inactive/terminated I have not been seen in the clinic for nine (9) or more months. At that point Dr. Aponte will no longer be considered my physician of record.

Name: _____

Signature: _____

Date: _____