HOUSTON ADULT PSYCHIATRY
2180 North Loop West, Suite 450, Houston TX 77018
TEL: (832) 384-1560
FAX: (832) 384-1585

Frank Chen, MD PA ***Michael Barber, MD PA***

Please fill in the following 5 pages and give to your front office staff. Please print information clearly.

Patient Information

First Name: _____ Last Name: _____

Date of Birth:_____ Age: _____ ( ) Male ( ) Female

Address: _____ Apt: _____

City: _____ State: _____ Zip:_____

Main Number: (_____) _____ - _____ Alt Number: (_____) _____ - _____

Email: _____(used for appointment reminders)

Pharmacy Name: _____ Pharmacy Number: (_____) _____ - _____

Emergency Contact Information

Name: _____

Relationship to Patient: _____

Main Contact Number: (_____) _____ - _____

Release of Information to Individual

☐ **NO**, I do not want HAP to share any information or communicate with anyone on my behalf.

☐ **YES**, I give Houston Adult Psychiatry permission to communicate with the following person on my behalf. I can revoke release at any time by notifying the office of any changes.

☐ ALL ☐ Scheduling/CA appointments. ☐ Treatment ☐ Paperwork ☐ Medication/ Refills

Person's Name: _____

Relationship to Patient: _____

Main Contact Number: ( ) _____ - _____

IF YES: Patient's Signature: _____ Date: ____/____/_____

Consent for Treatment

I _____ give full consent to receive services until I notify my attending provider that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself.

Date: _____/_____/_____ _____

Today's Date Signature (client)

AUTHORIZATION TO PAY BENEFITS

I request that payment of authorized insurance benefits be made on my behalf to *Frank Chen, MD and Michael Barber, MD* for professional services rendered to my dependent or me. I further understand that I am responsible for all outstanding charges not paid by my insurance. The undersigned is financially responsible for fees not paid pursuant to this agreement. I authorize any holder release of medical information as may be necessary for the completion of my insurance claims to any insurance carrier, health or hospital plan. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Insured or Responsible Party Today's Date

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CLIENT'S RIGHTS

1. **You have all the rights of any other resident of the State of Texas and the United States of America.**
2. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
   (Client's Rights Cont.)
3. **You have the right to be free from abuse, neglect and exploitation.**
4. You have the right to be treated with dignity and respect.
5. **You have the right to be told about the treatment you will be given, the risks, Side effects, and benefits of all medications and treatment you will receive, the other treatments that are available, and what may happen if you refuse treatment.**
6. You have the right to accept or refuse treatment after receiving this explanation.
7. **You have a right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.**
8. You have the right to know the qualifications of the staff responsible for your treatment.
9. **You have the right to refuse to take part in research without affecting your regular care.**
10. You have the right not to be given medication you don't need, or too much medication.
11. **You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.**
12. Unless otherwise provided by law, you have the right to withdraw at any time your permission for something you agreed to earlier.
13. **You have the right to make a compliant and receive a fair response from this facility within a reasonable amount of time.**
14. You have the right to contact and consult with counsel at your expense.
15. **You have the right to select practitioners of your choice at your expense.**
16. You have the right to choose whether your parents may be present and participate in your treatment if you are at least 18 years of age.

(THE CLIENT'S RIGHTS HANDOUT IS AVAILABLE ON REQUEST FROM FRONT OFFICE STAFF.) I acknowledge having read and understood **the above** client rights.

_____ _____
(Signature of Patient) Date

_____ _____
(Signature of Parent or Legal Representative) Date

_____ _____
(Signature of Witness) Date

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Office Policies

We appreciate the opportunity to work with you. The following information is provided for your benefit so that we might serve you better. *Please initial each policy to verify agreement and sign at the bottom of this form*.

OFFICE VISITS – All office/outpatient visits or fees, are payable at the time of service. We accept cash, MasterCard, VISA, American Express, and Discover. (NO CHECKS.) **(Initial)** _____

CHILDREN - For the comfort of our patients, ***children under the age of 10 are not allowed in the office***. If children of any age are disruptive, you will be asked to reschedule your appointment. **(Initial)** _____

FEMALE PATIENTS – If taking medications, I agree to notify my provider in the event that I am planning to become pregnant or I become pregnant so that I may discuss the risks/benefits of medication. **(Initial)** _____

ALCOHOL/DRUGS/HERBAL SUPPLEMENTS – It is recommended not to use alcohol/drugs or herbal supplements in combination with prescription psychiatric medication and I agree to notify my provider of any usage. **(Initial)** _____

MEDICATION REFILLS - Medication is prescribed to last until your next appointment. If you required medication refills you will need to be seen in office. ***We reserve the right to deny medication refill when appointments are not kept.*** **(Initial)** _____

MEDICATION CHECKS – Medication checks are scheduled for 15 minutes. Please be prompt for your appointment. ***IF you are over 15 minutes late you appointment will have to be rescheduled.*** **(Initial)** _____

ADDITIONAL CHARGES- We charge for the completion of paperwork, letters, forms, etc. Fees will be determined by your provider***. Fees are due at the time forms are completed*.** **(Initial)** _____

MANAGED CARE PLANS – In agreement with our managed care plans, all co-payments or fees must be paid at time of service. It is your responsibility to be aware of your coverage plan. Any denied coverage of visit amounts would be due immediately. **(Initial)** _____

CANCELLATIONS – I agree to cancel my appointment 24 HOURS BEFORE MY APPOINTMENT TIME. Failure to cancel prior to appointment time can result in **a $50.00 no show fee**. Multiple no shows or less than 24 hr. cancellation will not be scheduled and will be referred to another psychiatrist office. (**Initial)** _____

AFTER HOUR SERVICES – There is a 24-hr. paging system for emergency situations. This is for emergency situations only (no medication refills will be given). ***There is a $50.00 charge for non-emergent after hour calls.*** **(Initial)** _____

EMERGENCY SERVICES – I agree to contact ***my provider or 911*** in the event that I feel suicidal or violent in order to follow steps to protect the safety of others and myself. **(Initial)** _____

BILLING INQUIRY- Billing questions, hospital charges and past due balances are handled by our billing department at (281) 466-1891 or through our website at www.houstonadultpsychiatry.com and click on billing link. **(Initial)** _____

LABORATORY/ DIAGNOSTIC TESTING –This office is not responsible for obtaining authorization for these tests. Pease contact your insurance company for a listing of preferred providers. **(Initial)** _____

INSURANCE INFORMATION – ***I am aware that I need to notify any changes in my insurance to HAP staff at least 24/48 hrs. before your appointment*** .. Submit new info by fax, calling our office or by our website. *New insurance without* verification will result in a co-pay of the allowable amount designated by your insurance company.

I have read and understand the above policies and agree to the terms regarding payments and payment responsibilities.

_____ _____
(Signature of Patient) Date

_____ _____
(Signature of Parent or Legal Representative if applicable) Date

Witness: _____

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Authorization to Disclose to Primary Care Physician (PCP)

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.(***Please check one of the following***)

☐ **NO, I do not** have an existing primary care physician. ***(if checked please skip the boxes below and sign and date the form)***

☐ **YES, I do have a PCP**: (***If checked, please fill in the formation in the box below***)

PCP Name: _____

Practice Name: _____

PHONE: (_____) _____ **-** _____ **FAX (_____)** _____ **-** _____

Address: _____

City: _____, **Sate:** _____ **Zip:** _____

I, _____ _____/_____/_____
(Patient name- print) (Patient DOB)

☐ **AUTHORIZE** ☐ **I DO NOT AUTHORIZED**

HOUSTON ADULT PSYCHIATRY to disclose any applicable behavioral health information (including diagnosis, treatment plan, prognosis and medication(s) to the PCP indicated in the box above for the purpose of collaboration of care. I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my consent.

_____ _____ / _____ / _____
Patient Signature (Patient over 18) **Date (required)**

_____ _____
Personal Representative (if applicable) Signature **Relationship to patient (required)**

PATIENTS – DO NOT WRITE BELOW LINE

To: Dr. _____,

A psychiatric evaluation was conducted on our mutual patient (name above) on _____/_____/_____

with the following Working Diagnosis: _____

Medication(s)/dosage(s) initiated: _____

Labs/tests ordered: _____

☐ I have requested that this patient consult you RE: _____

_____

☐ I have also referred this patient to: _____

I have consent from the patient to communicate with you to facilitate collaboration of care.

Please feel free to contact me at (832) 384-1564.

Sincerely, ☐ **Frank Y. Chen, MD** ☐ **Michael Barber, MD**

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Authorization to Disclose to Behavioral Health Provider

Communication between our behavioral health provider and your other existing behavioral health providers is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows us to share valuable information with your existing behavioral health providers. No information will be released without your signed authorization. Once completed and signed, please give this form to our staff.
(***Please check one of the following***)

☐ **NO, I do not** have an existing Behavioral Health Provider. ***(if checked please skip the boxes below and sign and date the form)***

☐ **YES, I have a: ☐ Therapist ☐ Psychologist ☐ Counselor**: (*If checked, please fill in the formation in the box below*)

Providers: _____

Practice Name: _____

PHONE: (_____) _____ - _____ **FAX** (_____) _____ - _____

Address: _____

City: _____, **Sate:** _____ **Zip:** _____

I, _____ _____/_____/_____
(Patient name- print) (Patient DOB)

☐ **AUTHORIZE** ☐ **I DO NOT AUTHORIZE**

HOUSTON ADULT PSYCHIATRY to disclose any applicable behavioral health information (including diagnosis, treatment plan, prognosis and medication(s) to the BHP indicated in the box above for the purpose of collaboration of care. I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my consent.

_____ _____ / _____ / _____
Patient Signature (Patient over 18) **Date (required)**

_____ _____
Personal Representative (if applicable) Signature **Relationship to patient (required)**

PATIENTS – DO NOT WRITE BELOW LINE

To: _____,

A psychiatric evaluation was conducted on our mutual patient, on _____/_____/_____, with the following working diagnosis: _____.

☐ I have also referred this patient to: _____ for _____.

I have consent from the patient to communicate with you to facilitate collaboration of care.

Please feel free to contact me at (832) 384-1564.

Sincerely, ☐ **Frank Y. Chen, MD** ☐ **Michael Barber, MD**