Today’s Date: Click dropdown DOB: Click dropdown

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| **Patient’s Name:** Enter First name, Middle initial, and Last Enter Preferred nameFirst, MI, and Last name Preferred name**Sex:** [ ] M [ ] F **Marital Status:** [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ] Partnered [ ] Other **Mailing Address:** Street, City/State, ZipHome phone: Click to input Mobile: Click to input Work: Click to inputE-mail: Click to input SS#: Please provide full socialPreferred Language: Choose from dropdownRace: Click to enter text. Ethnicity: Click to enter text. |

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| **Emergency Contact**: Enter phone # here Enter name here Enter relation here Phone # Name Relation |

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| **If Patient is a Minor:**Mother’s Name: Enter first and last name here if applicable Phone #: Enter phone # hereFather’s Name: Enter first and last name here if applicable Phone #: Enter phone # here |

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| **Insurance Information**[ ]  No Insurance: PPAYPrimary Insurance: Enter name of insurance here Phone #: # Should be listed on back of cardMember ID: Enter member ID# here Group #: Enter group # here if applicablePolicy Holder: Enter first and last name of policy holder DOB: Click dropdownPolicy Holder SS#: Enter full social security number hereSecondary Insurance: Enter name of insurance here Phone #: # Should be listed on back of cardMember ID: Enter member ID# here Group #: Enter group # here if applicablePolicy Holder: Enter first and last name of policy holder DOB: Click dropdownPolicy Holder SS#: Enter full social security number here |

**Consent to receive Call/ Text or Email for Appointment Reminders:**

**Patients in our practice may be contacted via call or text messaging and email to remind you of an appointment.**

If at any time I provide an email or phone number at which I may be contacted, I consent to receiving appointment reminders at that email or phone number from the Practice.

Initial here (Patient Initials) I consent to receive calls or text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders.

The phone number that I authorize to receive (CHECK ONE) [ ] phone call or [ ] text messages for appointment reminders is Enter phone # here.

The email that I authorize to receive email messages for appointment reminders and general health reminders is (If you prefer to not receive emails write “N/A”) Enter email here or N/A

*The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

Patient name (Print): Enter patient full name here Date: Click dropdown

Patient/Guardian signature: Enter signature here Date: Click dropdown

**Consent for Treatment**

I have chosen to receive mental health services for myself and/or my child from PSISA via in person or HIPAA compliant telehealth services if/when appropriate. My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

**Nature of Mental Health Services**: I understand that during the course of treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

**Compliance with treatment plan**: I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

**Supervision**: I understand there are certain circumstances which may require PSISA provider(s) to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision
2. Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed
3. The standards of care which guide most mental health professional recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others
4. Other special circumstances, such as preparation to testify in court

**Client Rights**

* The right to be treated with dignity and respect by all staff
* The right to be involved in the planning and/or revision of my treatment plan
* The right to know about my treatment progress or lack thereof
* The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used
* The right to be spoken to in a language that is fully understood
* The right to a clean and safe environment
* The right to refuse to be videotaped, audio recorded, or photographed
* The right to end treatment at any time unless court ordered
* The right to file a complaint or grievance about the agency or staff
* The right to confidentiality of clinical records and personal information according to federal and state laws

**Emergencies**: I understand I may reach my PSISA provider(s) at (210) 541-8455. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life-threatening emergency situation, I may call 911.

I have read and understood all of the above

Patient/Guardian signature: Enter signature here Date: Click dropdown

**Hours of Operation:**

***Monday through Thursday from 8am-5pm, and Friday from 8am-2pm****.*

Phone calls will be transferred to our answering service during the following business hours:
Monday through Friday 8am-9am, 12pm-1pm, and Monday through Thursday 4pm-5pm.
You can always leave a message with the service and we will return your call as soon as possible.

**To better serve our patients, we have established the following practice guidelines. Please read and sign where indicated. Questions regarding any office policy can be directed to our office staff.**

**Missed Appointments (“No Shows”)/Late Cancellations:** Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than a 24-hour notice (business days), you may be subject to the missed appointment fee of **$90.00**. The same policy applies to missing an initial appointment without giving at least a 48-hour notice (business days), in which case the fee will be **$200.00**. If you miss/late cancel more than 2-3 times you will be at risk of being terminated and may need to find another provider elsewhere. **Your insurance company will not be billed for any fees associated with missed or last-minute cancelled appointments. You will be entirely responsible for any and all fees.**

**Patient Tardiness**: If you are more than **10 minutes late** to your appointment you may not be seen and may have to reschedule and may be considered as a missed appointment with a possible charge. A patient may be seen up-to midway of their appointment time and will be charged for a full session.

**Provider Cancellations:** Occasionally your provider may need to change his/her schedule, cancel, and reschedule appointments with you. You will be informed of this as far in advance as possible and/or reschedule. In the event of illness of your provider, we may unfortunately be forced to give you little or no notice regarding the absence and the need to reschedule your appointment. Please keep phone numbers and addresses updated so we can reach you.

**Copy of Records/FMLA/Disability forms**: If you would like your physician or other professional to obtain a copy of your records, a release of information must be signed. For initial FMLA/Disability forms, patients must be consistent with follow up appointments. **Please allow 3 to 5 business days for any paperwork to be filled out. There will be a $25.00 charge for the first page and $5.00 each additional page after for any paperwork/letters filled out by providers. For medical records there will be a $25.00 for the first 20 pages and $00.50 cents per additional page.** **All fees must be paid in advance**. Please inquire at front desk for costs.

**Emergencies: *If you have a life-threatening emergency please call 911.*** The Psychosomatic Institute of San Antonio has night and weekend coverage for emergencies only. We expect calls after 5pm and on weekends will be **reserved for emergencies only**. Any non-life-threatening emergency, call (210) 541-8455 and have the on-call provider return your call and address your situation.

**Court Appearances/ARD Meetings**: A subpoena is required for all court appearances. The individual requesting the court appearance will be responsible for any fees charged. This also applies to depositions, other related court matters and attendance for ARD meetings. Our charges for court/school related activities are generally greater than our typical charges for mental health services. The business office can provide more detail on this subject.

**Prescriptions:** Prescriptions are generally written in a quantity to last until the next scheduled appointment. If it becomes necessary for a refill to be called in outside of an appointment, a charge of **$15.00** will be applied to prescriptions and triplicate medications. A **$10.00** charge will be applied if a prescription must be rewritten due to loss or expiration. Requests for non-controlled prescription refills are to be faxed in by your pharmacy to (210) 541-9477 for approval. **Please allow up to 3 business days** for prescription refills to be approved. In general, prescription refills cannot be ordered or approved after business hours because your physician and chart may not be available.

**HIPPA Privacy Practice:** I acknowledge that I have been provided access to Psychosomatic Institute of San Antonio/Maldonado Psychiatric PA notice of HIPPA Privacy Practices (NPP). I understand that I can obtain a copy of the HIPPA Privacy Practices (NPP) form from the front desk or website.

**Office Policies:** I acknowledge that I have been provided access to PSISA/MPPA, Office Policies. I understand that I can obtain a copy of the Office Policies from the front desk or website.

**Financial Agreement and Third-Party Consent:**

* Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company. We file your insurance claim as a courtesy to you.
* ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. **We ESTIMATE your co-payments according to your policy. We DO NOT in any way guarantee that your insurance will pay this amount.**
* I authorize payment directly to Psychosomatic Institute of San Antonio/Maldonado Psychiatric PA, the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims; and to communicate with my insurance to coordinate treatment, facilitate quality treatment, and obtain reimbursement. By not signing consent, I am agreeing to full payment at time of service.
* I understand and agree that, regardless of insurance status, I am responsible for the balance on this account, for any professional services rendered. I certify that the information I have provided is true and correct. I will notify Psychosomatic Institute of San Antonio/Maldonado Psychiatric PA of any changes in the above information, including insurance coverage in a timely manner.
* If the insurance company doesn’t pay within 60 days, it is required that you pay the balance due.
* Account balances not paid within 120 days of service may be turned over to collections agency.

**Patient Advocate:** Suggestions to improve what we do and the service we provide to our patients are welcome anytime. These suggestions along with any complaints, questions, praise, or concerns about any Psychosomatic Institute of San Antonio administrative staff are also welcomed.

Patient’s Name (Print): Enter patient’s full name here

Responsible Party (Print): Enter full name here Relation: Enter relation to patient here

Signature of Responsible Party: Enter signature here Date: Click dropdown