



Your Family Psychiatrist

Dear New Patient,

We are glad that you have chosen Your Family Psychiatrist, PLLC to provide this important aspect of your health care. We are committed to providing the most caring, professional, and confidential services possible. Our unique office arrangement is meant to bestow a more comfortable and relaxed environment than is customary in most physician offices.

The first appointment is a complete Psychiatric Evaluation. When you arrive with your completed paperwork, please flip the light switch in the waiting room that corresponds with your clinician to let us know that you are ready for the evaluation. Your psychiatrist will call your name and invite you into the office where you will spend approximately 1 hour in an interview type setting. Your psychiatrist will discuss your current concerns and review your complete medical history, psychiatric history, social history and family history. At the end of the interview, your psychiatrist will discuss diagnostic impressions and treatment recommendations.

Important Issues:

1) INITIAL PAPERWORK

The Intake Questionnaire is required to be completed **prior** to the appointment. The estimated time to complete the initial paperwork is 30 to 45 minutes. The doctor needs **ALL** the requested information in order to make an accurate differential diagnosis. Please bring the **completed** paperwork with you to the first appointment. Please plan on arriving 15 minutes prior to your scheduled initial appointment. If you arrive after your appointment time, the evaluation may be abbreviated in order to stay on schedule and not delay the next patient's appointment. We try our best to stay on schedule for our patients so you are never waiting long to see your doctor!

2) OFFICE LOCATION

From US-290:

Take Barker Cypress Road south. Take a left on Queenston Blvd. Make the 2nd available U-turn to enter the Queenston Business Park. Once you enter the Queenston Business Park, take your first left (immediately after the day-care center). We are the last suite on your right.

From Barker Cypress heading north:

Take a right into the Sherwin Williams paint store entrance immediately after Queenston Blvd. Our office is immediately behind Sherwin Williams.

Please call our office at (281) 849-4080 if you get lost or have any additional questions.



Your Family Psychiatrist

3) FINANCIAL POLICY

Payment is expected prior to being seen by your psychiatrist. We accept CASH if paid at least 48 hours in advance and all major CREDIT CARDS. The following is a brief list of services:

Initial Evaluation \$275.00
Medication Therapy \$150.00

Regarding Insurance

We will provide you with documentation necessary to file an insurance claim on your own. Your insurance plan may reimburse you directly. Please contact your insurance company to determine your benefit. Your Family Psychiatrist does not accept assignment of benefits and does not participate in any network. Your Family Psychiatrist will be considered an out-of-network provider by your insurance plan. We have no agreements to offer discounts for specific plans.

Missed Appointments

Unless canceled at least 2 business days in advance (48 hours prior notice not counting weekends), our policy is to charge for missed appointments at the full fee. Your Family Psychiatrist does not double book appointments. Your appointment time is reserved for you. Please help us to serve you better by keeping scheduled appointments.

I have read, understand and agree to abide by the above financial policies regarding service fees and missed appointments.

Name

Signature

Date



Your Family Psychiatrist

Adult Intake Questionnaire

Thank you for taking the time to answer the following questions. Please complete this form to the best of your knowledge. If some questions are not applicable to you, write N/A. If you need additional space, please feel free to write on the back of the sheet. This information is very helpful in making an accurate diagnosis.

Date: _____

Person completing this form: _____

What is the reason that you have sought an appointment at this time?

A. General Information

First Name:			Address:		
Last Name:			City:		
DOB:			State:		
Current Age:		Sex: M F	Zip Code:		
Primary Phone:			Driver's License:		
Secondary Phone:			Employer:		
Email:			Student Status:	None	Part Time Full Time
Emergency Contact:			Primary Phone:		
Relationship to patient:			Secondary Phone:		

B. Developmental and Social History

Family Background and Childhood History

Were you adopted? Yes No

Where were you raised? _____

How old were you when you left home? _____

Has anyone in your immediate family ever died? No Yes If so, who and when? _____

Educational History

What kind of grades did you make? _____

What things got you in trouble in school? _____

Did you attend college? Yes No Where? _____ Major? _____

Highest educational level or degree attained? _____

Occupational History

Are you currently working? Yes No How long in current position? _____

What is your occupation? _____ Where do you work? _____

Marital Status/ Current Family

Marital Status: Single Married Separated Widowed Divorced

How long in current status? _____ If married, what is your spouse's occupation? _____

Describe your relationship with your spouse or significant other:

Have you had previous marriages? Yes No If so, how many? ____ For how long each? _____

Do you have children? Yes No Ages: _____

Religion

What is your religious affiliation? _____

Do you attend regularly Yes No

C. Medical Information and History

Primary Care Physician:

Name _____ Phone # _____ Address: _____

Pharmacy:

Name _____ Phone # _____ Nearest Intersection: _____

Please list any medical illnesses that you have (such as asthma, anemia, etc.):

Allergies: _____

Current non-psychiatric medications and supplements (please include current dose and reason for medication):

D. Previous Mental Health History

Have you ever been placed on medication for treatment of emotional/behavioral problems (see next page)?

No Yes, please list below:

Name of Medication:	Dose:	For What:	Effects (improvement):			Side Effects (Please specify)
			None	Slight	Much	
Current:						
Past:						

Have you ever been admitted to an inpatient psychiatric hospital, a residential treatment program, or a rehabilitation facility? No Yes, please list below.

Name of hospital/ Facility	Date of admission	Duration of stay	Reason for admission

Have you ever attempted suicide? No Yes, please explain method and date of attempt:

E. Substance Abuse History

Chemical:	Last Use:	Amount:	How Often Used:	How Long Used
Alcohol				
Marijuana				
Cocaine/ Crack				
Inhalants				
LSD				
Prescribed Pills				
Heroin				
Other (specify)				

Have you experienced any of the following due to alcohol and/or illegal substance use:
 Blackouts Withdrawal symptoms Cravings Overdoses

Have you ever experienced legal problems (including arrest) due to alcohol and/or illegal substances.
 No Yes, please explain _____



Your Family Psychiatrist

Consent for Treatment

The undersigned patient or responsible party (parent, legal guardian, or conservator) consents to and authorizes services by Your Family Psychiatrist, PLLC. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures, and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Consent for the services outlined above.
2. Be informed of and participate in the selection of treatment modalities.
3. Receive a copy of this consent.
4. Withdraw this consent at any time.

Name of Patient or Legal Guardian (please print)

Relationship to the patient

Signature

Date

Acknowledgement of Receipt of Office Policies 2019 and HIPAA Notice of Privacy Practices

Please sign below to confirm that you have received the Your Family Psychiatrist Office Policies and HIPAA Notice of Privacy Practices.

I acknowledge receipt of, and agree to follow, these office policies. I also acknowledge receipt of the HIPAA Notice of Privacy Practices. I have had an opportunity to call and ask questions about the policies and practices:

Name of Patient or Legal Guardian (please print)

Relationship to patient

Signature

Date



Your Family Psychiatrist

Consent for Electronic Communications

I understand that the office policies allow Your Family Psychiatrist to communicate with me via email and other electronic media regarding matters related to my care. I have provided you with my email address and telephone number, and I acknowledge that I am responsible for keeping my email address and telephone number updated. I am able to receive information electronically and store it securely away from any public computer. I acknowledge that I can change or withdraw my consent to electronic communications at any time.

I understand that I may elect now to opt out of automated appointment reminders by placing my initials by the appropriate OPT OUT election below:

I elect to OPT OUT of automated email appointment reminders _____ (initials)

I elect to OPT OUT of automated text appointment reminders _____ (initials)

I elect to OPT OUT of automated telephone appointment reminders _____ (initials)

Name of Patient or Legal Guardian (please print)

Relationship to patient

Signature

Date



Your Family Psychiatrist

Credit Card Charge Authorization

I understand that full payment is required at the time of service by either cash or credit card. Full payment is also required for missed appointments and cancellations with less than 48 hours prior notice (not counting weekends).

I also understand that the financial responsibility for services provided is mine, and that I must file for any insurance reimbursement to which I may be entitled because Your Family Psychiatrist, PLLC will not file insurance claims on my behalf.

I understand that the credit card listed below will be charged for services rendered and for the missed and cancelled appointments with less than a 48-hour notice. If the credit card charge is denied, I will be billed separately for the appointments. Your Family Psychiatrist will not schedule any further appointments until I pay all outstanding balances.

I agree to call and notify the receptionist in advance of my next scheduled appointment if my address, phone number, or responsible party has changed.

I hereby authorize Your Family Psychiatrist, PLLC to charge my credit card for services rendered to me or the patient whose name appears below (and for appointments missed or cancelled with less than a 2-business-day-notice) at a rate of \$275 for the initial appointment or \$150 for each follow-up appointment.

Credit Card No.: _____ Exp. Date: _____

Name (as printed on card): _____

Billing Address (shown on the card statement): _____

City: _____ State: _____ Zip Code: _____

By signing below I am authorizing Your Family Psychiatrist, PLLC to charge my credit card for the professional services as described above. I certify that I am the owner of the credit card listed on this form and can authorize charges to this card.

Patient's Name

Date

Responsible Party's Name

Date

Responsible Party's Signature

Date

TELEPSYCHIATRY INFORMED CONSENT

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist and the patient are not in the same physical location. Your Family Psychiatrist, PLLC allows its psychiatrists to perform telepsychiatry after the initial face-to-face evaluation, and between annual face-to-face re-evaluations, but only through the telemedicine service provider Doxy.me, LLC. The interactive electronic systems used by Doxy.me incorporate network and software security protocols to protect the confidentiality of patient information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Telepsychiatry Benefits:

- Increased accessibility to psychiatric care.
- Patient convenience.

Potential Telepsychiatry Risks:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision-making by my psychiatrist.
- Delays in psychiatric evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.
- In rare cases, a lack of access to all the information that might be available in a face-to-face visit, but not in a telepsychiatry session, could result in the omission of care involving other health problems or possible adverse drug interactions.

If I decide that the benefits outweigh the risks, I may request telepsychiatry sessions when I schedule follow-up appointments. If my psychiatrist agrees, I will be scheduled for a telepsychiatry session, and I will be sent an internet link (to <http://Doxy.me>) with instructions to log into the “waiting room” immediately prior to my scheduled appointment.

My Rights:

- (1) I understand that all laws protecting the privacy and confidentiality of medical information also apply to telepsychiatry.
- (2) I understand that all the Texas rules and regulations which apply to psychiatry also apply to telepsychiatry.
- (3) I understand that my psychiatrist has the right to withhold or withdraw his consent for the use of telepsychiatry at any time during the course of my care.
- (4) I understand that I have the right to withhold or withdraw my consent for the use of telepsychiatry at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment from my psychiatrist.

My Responsibilities:

- (1) I understand that I must be physically within Texas (including offshore State waters) to be eligible for telepsychiatry, and my psychiatrist can send prescriptions for medications only to Texas pharmacies or addresses. I will inform my psychiatrist as soon as my session begins of my physical location.
- (2) I will ensure the proper configuration and functioning of all my electronic equipment prior to my session because the computer, tablet, or mobile telephone I use must have working camera and audio input so that my psychiatrist can see and hear me in real time.
- (3) I will not record any telepsychiatry sessions without written consent from Your Family Psychiatrist, PLLC, and I understand that my psychiatrist will not record any of our telepsychiatry sessions without my written consent.
- (4) I will inform my psychiatrist as soon as my session begins if any other person can hear or see any part of our session.
- (5) If I lose my connection during a session, I will immediately attempt to log back into the <http://Doxy.me> “waiting room”.
- (6) If the audio I am receiving during a telepsychiatry session is not complete and clear, I will attempt to let my psychiatrist know or telephone Your Family Psychiatrist, PLLC to schedule a new appointment.

Patient Consent to the Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize my psychiatrist to use telemedicine in the course of my diagnosis and treatment. I agree to hold Your Family Psychiatrist, PLLC and its psychiatrists harmless from injuries or omissions that may be related to the malfunction or technical failure of equipment or system encryption.

Printed name

Date

Signature of patient (or parent, legal guardian, or conservator)

(Relationship to patient)