Your Family Psychiatrist

Dear New Patient,

We are glad that you have chosen Your Family Psychiatrist to provide this important aspect of your child's health care. We are committed to providing your family with 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. The initial evaluation is quite thorough, so please plan to be present at our clinic for approximately 2 hours. If your child can not be left alone in the waiting room during the parent interviews, please bring another adult to watch the child. Please do not bring siblings or other children to the initial appointment.

Important Issues:

1) INITIAL PAPERWORK

The Child Intake Questionnaire is required to be completed **prior** to the appointment. The estimated time to complete the initial paperwork is 30 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 time. 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. If we do not have enough time to complete the evaluation, you may have to schedule an additional appointment to complete the initial evaluation. 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.

3) FINANCIAL POLICY

Your Family Psychiatrist

Payment is expected prior to being seen by your psychiatrist. We accept CASH and all major CREDIT CARDS. The following is a brief list of services:

Current charges:
Initial Evaluation $315.00
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 benefits. 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, acknowledge and agree to abide by the above financial policies regarding service fees and missed appointments.

_____	_____	_____
Name	Signature	Date

12250 Queenston Blvd.● Suite E ● Houston, Texas 77095 ● Phone: (281) 849-4080

Your Family Psychiatrist

Child Intake Questionnaire

Please complete this form to the best of your knowledge. If you need additional space, write on the back of a page. This information helps us make accurate diagnoses.

Date: _____ Referred by: _____

Person completing this form: _____ Relationship to child: _____

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

_____

_____

A. General Information

Child's Name: _____ Date of Birth: _____ Age: _____

Sex: _____ Address of child (including city, state and zip code): _____

_____

*(A **copy of legal custodianship** needs to be provided if child is cared for by persons other than living biological or adoptive parents.)*

Marital Status of Parents

__ Married (for ____ years) __ Never Married __ Separated __Divorced __Widowed

If applicable, age of child when parents divorced: _____

If applicable, what is current custody arrangement: _____

(*If parents are divorced, please bring* a copy of the ***divorce decree*** *to the appointment.)*

Mother's Information

Mother's Name: _____ DOB: _____ Best Contact Phone#: _____

Address: _____

Email Address: _____

Currently employed: __No __ Yes, Job Title: _____

Father's Information

Father's Name: _____ DOB: _____ Best Contact Phone#: _____

Address: _____

Email Address: _____

Currently Employed: ___No __Yes, Job Title: _____

B. Residencies: Please provide the following information if your child has had **more than one residence -** For type of residence please signify home, foster home, institution, other:

Type of Residence	Dates from/ to	Reason for Placement	Results	Reason for Leaving

C. Education

Type of classroom placement (Regular, ED, LD, Resource, GT):

_____

Has this child ever repeated a grade? _____ If yes, which one(s), and for what reason(s)?

_____

School Educational Testing? __ No __Yes If yes, what was the date?

_____

Intelligence (IQ): __ Below Normal __ Normal __ Above Normal

Learning Disabilities (LD): __ No __ Yes If yes, in what area(s): _____

_____

Does this child currently receive any special education service(s) __No __Yes If yes, what type(s):

_____

_____

Please list any other school related problems:

_____

_____

(Please bring copies of school testing/ behavior referrals, progress reports, etc.)

D. Social History

How well does your child get along with:

Siblings:

_____

Parents:

_____

Teachers:

_____

Peers:

_____

What are your child's interests/hobbies?

_____

_____

E. Previous Mental Health History

Has the child been seen by any of the professionals listed below for emotional/ behavioral problems?

Check all that apply:

__ Counselor

__ Pediatrician

__ Psychiatrist

__ Psychologist

Please provide the following information for each professional checked (list current or most recent treatments first):

By Whom:	When:	Duration:	For What:	Result:
		From: To:		
		From: To:		
		From: To:		
		From: To:		

Has the child ever been placed on medication for treatment of emotional/ behavioral problems?

__ No __ Yes, please list below:

Name of Medication:	Dose:	Length of Trial:	Effects (improvement):			Side Effects: (Please specify)
			None	Slight	Much	
Current:		From: To:				
		From: To:				
		From: To:				
		From: To:				
		From: To:				
		From: To:				
Past:		From: To:				
		From: To:				
		From: To:				
		From: To:				

Has your child ever been admitted to an inpatient psychiatric hospital, a residential treatment program, or a rehabilitation facility? __ No __Yes, listed below:

Hospital/Facility name:	Date of admission	Duration of stay:	Reason for admission:

Has your child ever attempted suicide? __No __ Yes, please explain method and date of attempt:

_____

_____

F. Substance Abuse History

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

Has your child experienced any of these due to alcohol and/or illegal substance use: __ Blackouts __ Withdrawal symptoms __ Cravings __ Overdoses

Has your child ever experienced legal problems (including arrest) due to alcohol and/or illegal substances.

__ No __ Yes, please explain: _____

_____

G. Medical Information and History

Primary Care Physician:

Name _____ Phone # _____ Address _____

Preferred Pharmacy:

Name _____ Phone # _____ Nearest Intersection _____

Please list any other medical illnesses your child has (such as asthma, anemia, etc.)

_____

Allergies:_____

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

_____

_____

H. Developmental History

Pregnancy

Length in months (or weeks) if known: _____

Did the mother use any of the following during pregnancy?

Cigarettes	N	Y If yes, please specify quantity per day. _____
Alcohol	N	Y If yes, please specify quantity per day. _____
Drugs	N	Y If yes, please specify types and quantity. _____

Delivery

Type of birth delivery : __ normal __ breech __ cesarean section

Were there any problems with labor and delivery? __ No __ Yes, please specify.

_____

_____

Prenatal History

Number of days baby stayed in the hospital following his/her birth: __ days

Any birth defects __ No __ Yes, please specify: _____

_____

Infancy and Early Childhood

Are there any problems or comments regarding this child's infancy and early childhood development?

__ 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 Relationship to the patient

_____ _____

Signature of the parent, legal guardian, or conservator Date

Acknowledgement of Receipt of Office Policies 2015 and "HIPAA Notice of Privacy Practices"

Please sign below to confirm that you have received our Office Policies and HIPAA Notice of Privacy Practices.

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

_____ _____

Name of Patient or Legal Guardian (please print) Date

_____ _____

Signature Relationship to patient

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-busines- day-notice) at a rate of $315 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

12250 Queenston Blvd.● Suite E ● Houston, Texas 77095 ● Phone: (281) 849-4080

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)