**Psychiatric Medical Associates, P.A.**
**6404 International Pkwy, # 1010, Plano, TX 75093**
**Phone # 972-267-1988**
**Fax # 972-267-3434**

**Adult Intake Form**

Date: ____________________ DOB: ______________________________

Patient Name: ______________________________________________

Social Security # ______________________________________ Gender Identity: ___________________

Address: ____________________________________________________________________________

City: ________________________________ State: __________________ Zip: ________________________

Home phone # Cell # ________________________ Work # __________________

***In Case of an Emergency, who can we contact?***

Name:___________________________________________ Phone # ______________________________

Relationship: ______________________________________ Cell # ________________________________

***Can we release ALL personal health information to the following? (Please provide names)***

PCP: ___________________________________

Employer / HR Department: __________________ Psychiatrist: _______________________________

Social Security Department __________________ Doctor: ___________________________________________

Texas Dept. of Family and Protective Services-CPS Other: ___________________________________________

Attorney Office: If yes, please provide Attorney's name & phone # _______________________________________

***Insurance Information:***

Insurance company: ____________________________________ Member ID/ Policy # ______________________________

Group #:_________________________

Insurance phone #:_________________

Name of Primary Policy Holder:_______________________ Employer: ______________________________

Primary Holder's SSN:______________________ Primary Holder's DOB: _________________________

**Is Primary Policy Holder the Responsible Party?** Relationship to Patient: ____________________________

If No, Responsible Party / Guarantor's Information: **Yes** **No (Adult patients are responsible for their own financials)**

Responsible Party Name: ____________________________________Home/Cell Phone # __________________________

Address: ______________________________________________________________________________________

City: ___________________________________ State: ____________________ Zip: ____________________

Patient Signature: _______________________________________________ Date: ______________________

**ASSIGNMENT FOR BENEFITS**

I, ______________________________ authorize Psychiatric Medical Associates, P.A. to bill my insurance company for charges incurred during the course of my treatment and to provide any information necessary to process my claims and to collect payment. I authorize my insurance company to honor a photocopy of this authorization and to assign my insurance benefits for these charges to Psychiatric Medical Associates, P.A.

Sign: ______________________________________________ Date: ______________________________

Printed Name: ________________________________________

## Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

**Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

**Your rights regarding your health information**

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Psychiatric Medical Associates, P.A. at 972-267-1988.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Psychiatric Medical Associates, P.A. at 972-267-1988. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact 972-267-1988. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

   If you have any questions regarding this notice or our health information privacy policies, please contact 972-267-1988.

I ____________________________________ authorize Psychiatric Medical Associates, P.A. to release all information regarding my treatment to the following individuals:

Name: ______________________________________________ Relationship: _______________ __

Name: ______________________________________________ Relationship: _______________ __

I hereby acknowledge that I have been presented with a copy of Psychiatric Medical Associates, P.A.'s Notice of Privacy Practices.

________________________________

Signature

________________

Date

________________________________

Printed Name

## PSYCHOLOGICAL INTAKE INFORMATION - Adult

**Preferred Name:** ___________________________________________

**Gender Identity:** ___________________________________________

**Age:** ____________

**Sexual Orientation**

☐Heterosexual ☐ Gay/Lesbian ☐ Asexual ☐ Bisexual ☐ Undecided

**Ethnic Identity**

☐Caucasian/White ☐ Hispanic-American ☐ African-American ☐ Asian-American

☐ American-Indian ☐ South-Asian ☐ Other: _______________________

☐ Multi-Ethnic: ___________________________________________

☐ Non-US Citizen: ___________________________________________

Undocumented status is **NOT** reported to any government agency and will be kept confidential

**Referral Source**: ___________________________________________

**On the scale below please check the severity of your current problem(s):**

☐ mildly upsetting

☐ moderately severe

☐ very severe

☐ extremely severe

☐ totally incapacitating

- **In your own words, please describe what brings you in for counseling at this time?**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

• **Have you ever had feelings or thoughts of suicide?**

☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next section.

• **Do you currently feel that you don't want to live?**

☐ Yes ☐ No

**How often do you have these thoughts?** ______________________________

**When was the last time you had these thoughts?** ______________________________

**Have you ever thought about how you would kill yourself?** ______________________________

**Is there anything that would stop you from killing yourself?** ______________________________

**Have you ever tried to kill or hurt yourself before? Please explain.** ______________________________

**Do you have access to guns? If yes, please explain.** ______________________________

• **Past/Current Psychiatric History:**

☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next section.

Inpatient treatment in a psychiatric hospital ☐ Yes ☐ No

If YES, please state when, where and for what reason ______________________________

Outpatient treatment in a partial or IOP program ☐ Yes ☐ No

If YES, please state when, where and for what reason ______________________________

Individual, Couple, or Group Therapy ☐ Yes ☐ No

If YES, please state when, where and for what reason ______________________________

Psychiatrist for medication ☐ Yes ☐ No

If YES, please state when, where and for what reason ______________________________

**Employment History**

Please provide a general description of your work and any work related stressors or issues that may be occurring at this time (Frequent job loss, been fired, inability to perform well, etc.).

______________________________________________________________________________

______________________________________________________________________________

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? ____________________________________________

What is/was your occupation? ____________________________________________

Where do you work? __________________________________________________

Have you ever served in the military? ☐ Yes ☐ No

If so, what branch and when? ______________________________

Honorable discharge ☐ Yes ☐ No

Other type discharge ____________________________________

**Educational History**

Highest Grade Completed? __________

Did you attend college? ☐ Yes ☐ No

Where? _______________________ Major? _______________________

What is your highest educational level or degree attained? ________________________________________

Psychiatric Medical Associates

**Family Information**

Please include information such as name, age, occupation etc. Please describe the relationships in your family as best you can.

Father/ Stepfather

______________________________________________

______________________________________________

Mother/ Stepmother

______________________________________________

______________________________________________

Siblings

______________________________________________

______________________________________________

Children ______________________________________________

______________________________________________

Others you consider family

______________________________________________

______________________________________________

Have you or a close relative ever been hospitalized for a psychiatric illness? ☐ Yes ☐ No

Does anyone in your family have a mental illness? ☐ Yes ☐ No

Has anyone in your family every attempted or committed suicide? ☐ Yes ☐ No

Does anyone in your family have a substance abuse problem? ☐ Yes ☐ No

Have you or a family member ever been arrested? ☐ Yes ☐ No

- **Current Relationship**

Are you currently:

☐ Single ☐ Married (How long: __________) ☐ In a Committed Relationship

☐ Widowed ☐ Separated ☐ Divorced ☐ Living together ☐ Engaged

☐ Never Married

PMA
Psychiatric Medical Associates

• **What was the role of Religion in your life?**

______________________________________________

______________________________________________

• **Drug Use History**

This information is confidential.

☐ Marijuana ☐ Alcohol ☐ Opiates/Heroin ☐ Methamphetamines/Cocaine
☐ Prescription drugs ☐ Inhalants ☐ Ecstasy ☐ Prescription Medication abuse
☐ Hallucinogens ☐ Synthetic Drugs ☐ Other: ________________

**Please indicate how long and how often you have been using any of the above:**

______________________________________________

______________________________________________

**Please indicate any consequences you think you may have had as a result of your drug use (arrest, overdose, loss of relationships, work/school problems, withdrawal etc.):**

______________________________________________

______________________________

**Have you ever been treated for alcohol or drug abuse?** ☐ Yes ☐ No

If yes, when and where? ______________________________________________

**Do you think you may have a problem with alcohol or drug use?** ☐ Yes ☐ No

• **Medical History**

Please describe anything you think I should know about your medical history such as head injury, cardiovascular problems, significant illnesses, stroke, gastrointestinal problems, tic, etc.

______________________________________________

______________________________________________

______________________________________________

• **What goals would you like to accomplish in coming to treatment?**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Your confidentiality is of upmost concern. However, please be aware that, as a psychologist, I am required by the State of Texas to report any suspicion of abuse towards a child or elderly adult. If you have any questions about limits to confidentiality, please speak with me directly.**

I have read, understood, and agreed to the policy listed above for Psychiatric Medical Associates.

______________________________ ______________

Signature Date

______________________________

Printed Name

## General Office Policies and Procedures & Financial Agreements

Thank you for choosing Psychiatric Medical Associates, P.A. to be of service to you and your family for your behavioral healthcare needs. Please read these policies completely, and if you have any questions, do not hesitate to ask for clarification.

**Appointments:** Appointments are scheduled according to each patient's needs and the availability of the provider. The time of your appointment is reserved for you. You are expected to give 24 hours' notice with a staff member or with the answering service if you will not be keeping your appointment, **or it will be necessary for you to pay an unkept appointment fee of $100.** Your insurance company will not cover this fee. It is your responsibility. Repeated "no show" or "late cancelled" appointments could result in you being referred out of the clinic to another practitioner. We do not do phone appointments. In case of an emergency, where you cannot come to your regular scheduled appointment and you have to do a phone appointment, you will be charged $175 for the appointment. We cannot bill your insurance for the phone appointments, it is your responsibility.

**Maintaining Patient Status:** In our area of healthcare, it is very important that you be seen on a regular basis. At the end of each appointment, the doctor / nurse will tell you how long a period of time they would like you to schedule a follow-up appointment in the office. We urge you to make the follow-up appointment before you leave our office in order to schedule the most convenient time for you. **If you fail to keep and/or maintain follow-up appointments for a period of 120 days or greater, we will conclude that you have terminated the patient-physician relationship**.

**Phone Calls:** Emergency calls are handled as a priority. If you are experiencing a medical emergency, please call 911 immediately. Routine calls will be handled by our office staff during our normal business hours. Please leave a message on our voice mail or with our after-hour's answering service for the office staff. Your call will be returned on the next business day. Calls that require the doctor to call you back will be handled as timely as possible. Please leave your name, number and detailed message with our 24 hours answering service if your call is urgent and cannot wait until the office is open. Medication refills/pre-authorizations/scheduling appointments **are not considered emergencies**, so please do not have the doctors paged for such services.

**Payment for the services: Payment for the service is due at the time of service. Any past due balance needs to be paid before the next visit. We may need to cancel your appointment if you are unable to pay your balance in full prior to your next visit. We will send two monthly statements and one final collection letter and if the balance is unpaid, it may be turned over to outside collection agency. If you are unable to pay your balance in full, we can offer you a "No interest" payment plan where the minimum payment should be $100 per month and/or balance will have to be paid off in six installments / six months. First payment is due on the day payment plan is set up. Payment on the payment plan statements will be considered separate than you current visit costs which needs to be paid at time of service, regardless of your payments towards payment plan.**

**Credit Card on file policy**: We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $25 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.
Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Patients with insurance plans under Obamacare / Affordable Care Act, will have to pay the full visit cost upfront for each visit. We will bill your insurance, and if the insurance pays for the visit and doesn't ask for refund/recoupment in 4 months after your visit, we will refund you the credit.

## Other Fees

Medical records, disability forms, work excuses, school notes, calls to employers, return to work letters, etc. will be provided on a fee basis. **The fee must be prepaid in order for us to complete the requested task.** The fee will be based on time spent preparing the requested information.

**Medical Records**: **There will be a charge of $40.00 for the first 20 pages and $1.00 per page for every copy thereafter** for medical records. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery. **Please note it will take 7-10 business days for processing the records.**

**Letters/ Documentation:** There is a charge associated with any and all documentation that we may have to complete. The charges will be determined by the amount of time spent to complete the request.

**FMLA/Disability Paperwork: We DO NOT do FMLA/Disability paperwork**. In rare case, if we fill out FMLA/Disability paperwork, there will be a charge of $40 that you will have to pay. We will not be able to bill your insurance or your employer for that.

**Court Fees: If a deposition or opinion in court is required, there is a $300 per hour charge for the Nurse Practitioner and $500 per hour for the MD to go to court. The minimum charge is $1000 paid in advance.** The hourly charge is billed for preparation time, travel time, and any time spent with an attorney/ clerk for preparation. Travel costs (i.e. tolls, gas, and miles) will also be billed to you. Your insurance company will not be billed for any of these fees and you are solely responsible for them.

**All fees, including late cancellation and no show fee, are not final and subject to change at any time without notice based on the discretion of the practice.**

I have read, understood, and agreed to the policies listed above for Psychiatric Medical Associates. I accept the conditions for receiving service from **Psychiatric Medical Associates, PA and its providers**.

________________________ ______________

Signature Date

________________________________

Printed Name

By the signature below, I hereby authorize Psychiatric Medical Associates to **release and obtain** information with respect to any **physical, psychiatric, or drug/alcohol related condition** obtained during the course of diagnosis and/or treatment **to/from** individual(s) or healthcare provider(s) below. The type of information authorized includes, but may be limited to, that which is indicated below.

**Psychiatric Medical Associates, P.A.**
**6404 International Pkwy, # 1010, Plano, TX 75093**
**Phone # 972-267-1988**
**Fax # 972-267-3434**

| **RELEASE TO/OBTAIN FROM**<br>By identifying and initialing below you are giving the provider permission **to release and/or obtain psychiatric evaluation, reports of testing, most recent progress notes, treatment plans, medications, and lab reports.** | | | **INITIAL EACH SPECIFIC CONSENT TO RELEASE** |
|---|---|---|---|
| **Family Members or Significant Others** | Name/Relationship: | | Yes No<br>Initial ________ |
| | Contact Number: | | |
| | Name/Relationship: | | |
| | Contact Number: | | |
| **School RN/School Counselor** | Name: | | Yes No<br>Initial ________ |
| | Contact Number/Fax: | | |
| **Psychiatrist/Psychiatric Nurse Practitioner** | Name: | | Yes No<br>Initial ________ |
| | Contact Number/Fax: | | |
| **PCP** | Name: | | Yes No<br>Initial ________ |
| | Contact Number/Fax: | | |
| **Employer/HR Department** | Name: | | Yes No<br>Initial ________ |
| | Contact Number/Fax: | | |
| **Attorney** | Name: | | Yes No<br>Initial ________ |
| | Contact Number/Fax: | | |
| **Tx Dept of Family and Protective Services CPS** | Case Manager Name: | | Yes No<br>Initial ________ |
| | Contact Number/Fax: | | |
| **Other** | Name/Relationship | | Yes No<br>Initial ________ |
| | Contact Number/Fax: | | |

I understand that this authorization is voluntary and made at my discretion. I may cancel/revoke this authorization at any time by giving written notice of my desire to do so. **By initialing and signing I have given consent for both verbal and medical records to be released to/obtained from the identified individuals.**

______________________ ______________________ ______________________
Patient Name Patient Signature Date of Birth

______________________
Date

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## CREDIT CARD ON FILE POLICY

At Psychiatric Medical Associates, P.A., we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $25 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.
Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

**I authorize Psychiatric Medical Associates, P.A. to charge the portion of my bill that is my financial responsibility to the following credit or debit card:**

**☐ Visa ☐ MasterCard ☐ Discover ☐ American Express**

**Credit Card Number** ____________________________________________

**Expiration Date** _____ / _____ / _____ **CVV # (Security code on back of card)** _________

**Cardholder Name** ____________________________________________

**Billing Address** ____________________________________________

**City** ____________________ **State**______ **Zip** __________

**Signature** ____________________________________________

I (we), the undersigned, authorize and request Psychiatric Medical Associates, P.A. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Psychiatric Medical Associates, P.A.
This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Psychiatric Medical Associates, P.A. in writing and the account must be in good standing.

Patient Name (Print): ______________________

Patient Signature: ________________________

Date: ____/ ____/ ________