NEW PATIENT REGISTRATION

Patient Name		Preferred		DOB
Email				
Birth Gender		Marital Status		
Social Secutrity Number		Driver's License #		State
Cell	Home	Work	Communication Preference	
Street Address (for mailing):			Apartment/Unit #:	
City		State	Zip Code	

INSURANCE INFORMATION

PRIMARY Insurance Carrier:		Member ID #		Group #
Subscriber Name	Relationship		DOB	SSN
SECONDARY Insurance Carrier:		Member ID #		Group #
Subscriber Name	Relationship		DOB	SSN

MEDICARE RECIPIENTS ONLY - Do you have secondary Insurance?

SECONDARY Insurance Carrier:		Member ID #		Group #
Subscriber Name	Relationship		DOB	SSN

Referred by	Primary Care Doctor		Telephone #
Last Physical Exam		What reason?	
Occupation	Employer		Education Level
Race/Ethnicity		Religion	
Sexual Orientation		Gender Identity	

CONTACT IN CASE OF EMERGENCY

Primary Contact Name	Relationship to Patient	Cell #
Secondary Contact Name	Relationship to Patient	Cell #

Treatment Authorization: I authorize Dr. Michael Musgrove and his representatives to provide me with medical care and services**.**

Medical Information: I authorize Dr. Michael Musgrove and his representatives to release any and all information acquired during treatment to other treatment facilities and providers to whom I am under care on an emergent basis, or to persons or entities directly responsible for payment of services (if applicable). I further authorize Dr. Musgrove and his representatives to access electronic prescription history databases for the purpose of my medical care and safety.

Payment agreement: I agree I am financially responsible for the payment fee(s) for service even though insurers may or may not reimburse me.

TREATMENT HISTORY

Why are you seeking help today?

Current Medications | Medication History

Have you ever been hospitalized for mental health reasons?

Facility/Location | Reason | Date

Facility/Location | Reason | Date

Facility/Location | Reason | Date

Have you ever been treated for chemical dependency (ie. detox, rehab)?

Facility/Location | Reason | Date

Facility/Location | Reason | Date

Current Psychiatrist | Since | Last Visit

Have you tried Counseling(ie. talk therapy, CBT)? | Current?

Name of Therapist/Center	Dates	Frequency	Last Visit

MISCELLANEOUS

Place of Residence (if different from mailing address)

Street | Apt/Unit#

City | State | Zip Code

Do you share this residence with anyone else?

Name | Age | Relationship

Name | Age | Relationship

Name | Age | Relationship

Name | Age | Relationship

Name | Age | Relationship

I consent to a photograph (drivers' license style) being taken of me, or to provide one for the exclusive purposes of adding the photo to my digital medical chart. I understand this photo will serve two purposes; 1) as a secondary identifier to avoid office confusion and 2) for providers and staff in recognizing you/prompt familiarity.
I understand that I may decline the photo consent but is not recommended for the above safety reasons. I consent to my photo taken or to be provided to the office:

Patient Name | Signature

Date:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT DETAIL, AUTHORIZATION

_____

OTHER NAME(S) USED _____

DATE OF BIRTH _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE _____

EMAIL ADDRESS _____

I, _____ hereby authorize Dr. Michael Musgrove and his authorized representatives to disclose and/or obtain my individually identifiable health information as described below, which may include information concerning communicable disease such as HIV/AIDS, mental illnesses, chemical or alcohol dependency, laboratory results, medical history or treatment, or other such related information or materials. I understand this authorization is voluntary and I may refuse to sign. I understand my health care will not be affected if I do not sign this form.

Under HIPAA, it is important to know: The Privacy Rule does not require the clinic to obtain a signed consent form before sharing information for treatment purposes. Healthcare providers can freely share information for treatment purposes without a signed patient authorization.

WHAT INFORMATION CAN BE DISCLOSED?

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Progress Notes
- ☐ Other_____
- ☐ Lab Results
- ☐ Diagnostic Test Reports

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

FAMILY MEMBERS:

OTHER (CPS, COUNTY, ATTORNEY ETC.):

☐ Check this box if you would like your medical records to be sent to the provider(s) listed below:

SPECIFIC DOCTORS/THERAPISTS:

I understand this authorization supersedes and revokes all authorizations previously on file.
I understand this authorization will expire in 365 days from the date of this authorization unless I specify another date.
I desire this authorization to expire on_____ [if applicable].
I understand I may revoke this authorization by issuing a written revocation to the office.
I acknowledge that there is no possible endangerment due to disclosure of my health information.

Signature_____ **Date**_____

CENTRAL TEXAS MENTAL HEALTH
1717 N Interstate 35 Ste 200, Round Rock TX 78664
www.centexmh.com | (512) 964-6992 | Fax (512) 610-5679 | frontdesk@centexmh.com

OFFICE POLICIES & PROCEDURES – CENTRAL TEXAS MENTAL HEALTH

The following list of policies will be enforced at all times to ensure the delivery of safe and effective care.

APPOINTMENT POLICIES

1. In consideration of all patients, individuals who arrive more than five minutes late may need to reschedule their appointment. At the discretion of staff, this policy may be waived on a case-by-case basis and/or allow an abbreviated visit. If you are running late, please let us know as soon as possible.
2. Cancellations of scheduled appointments should be communicated by a minimum of 48 hours prior, to avoid fees. If a scheduled appointment is canceled or rescheduled with less than 24 hours of notice, that will be considered a late cancellation.
3. Fees will be charged as follows; **$35.00** for no-shows, and **$20.00** for late cancellations.
4. Three no-shows or late cancellations in 12 months may result in the termination of our professional relationship.
5. Although staff may regularly confirm appointments one to two days ahead, it is the responsibility and expectation of the patient to attend follow-up appointments. Follow-up appointments are typically scheduled following each visit to foster continuity of care and availability. Be sure to note your provider's order to follow up.
6. While staff and clinicians are normally available by phone, patients are encouraged to make or move up an appointment when a complaint or problem occurs regarding their mental health. Please reserve telephone inquiries to clinicians for issues that can be reasonably managed by phone, else scheduling an appointment is recommended. There may be a modest charge for evaluation or management done over the phone if the call length is 5 minutes or longer.
7. It is the responsibility of the patient to inform us of any changes in insurance, or other demographic information (address, telephone numbers, emergency contacts, releases of information, email).
8. Please do not bring children to the appointments who cannot sit in a waiting room alone safely and quietly. We reserve the right to refuse service if we deem the child too young to sit in the waiting room alone.
9. We do not see both spouses at our practice as patients, to avoid a conflict of interest in case of separation, divorce, or custody issues. Please ask our receptionist for a list of other providers if the need arises.

PAYMENT FOR SERVICES, COORDINATION OF BENEFITS

1. Account balances, payments, and copayments/coinsurance are due at the time of service. We reserve the right to discontinue our professional relationship if a balance is not resolved.
2. It is the responsibility of the patient to be aware of current insurance coverage policies. Please notify the office of your current deductible amount and accumulations, coinsurance, copays, pre-certification requirements, annual visit limits, and network status (out-of-network benefits, if applicable) when applicable. If you are unaware or unfamiliar with the terms of your policy, please contact the member services number located on your member ID card.
3. Coordination of Benefits is required and enforced by most third-party payers (commercial insurance companies, other sponsors) To avoid our services being denied for payment, it is the responsibility of the patient to review and comply with any correspondence received by payers (via mail, email, etc.)
4. If you do not have mental health insurance, or if a third-party payer fails to resolve the balance, you will be responsible and billed for services at our discounted cash rate, **$150.00** per visit for established patients and **$350.00** for new patient appointments.
5. There is a **$35.00** charge for returned checks.
6. Account balances of $100.00 or more must be attended to with the receipt of your 1st bill. If you are unable to pay your balance in full, you may be eligible for a payment plan. On the receipt of your 3rd unpaid bill, your account will be considered as pre-collection.

REFILL REQUESTS

1. All refill requests must be submitted by your pharmacy. Requests may be submitted on your behalf via fax or electronically, by your pharmacy.
2. For timely processing and to avoid missed doses, please have your pharmacy submit their request at least five business days before your last dose.
3. In certain circumstances, you may need to call and speak to a staff member at your pharmacy. If instructed by the pharmacy, you may call the clinic for assistance. Adherence to this process may reduce the chance of error and avoid any fees (see below).
4. Texas law requires patients to be under medical supervision when taking controlled medication. You may be required to see a clinician before your medicine is refilled. Follow-ups are required to determine medical necessity.
5. If you have run out or have two or fewer doses remaining, this will be considered a late refill request. You may call the office to request the clinician call it into the pharmacy.

FORMS FOR DISABILITY, FMLA

1. Forms may require an additional appointment for the clinician to gather information specific to the required form.
2. Disability Forms require staff to adequately review, research, complete, and deliver to the intended recipient. As such, we charge a fee for each form's completion to compensate for its timely completion. **$95.00** will be charged to your account upon receipt of delivery.
3. Family Medical Leave Act (FMLA) forms similarly require staff's time and will be completed at an additional charge (per form). **$25.00** will be charged to your account upon receipt of delivery.
4. It is our goal and philosophy to return employees on leave or disability back to normal functioning and work status as soon as possible. This often includes a recommendation to enroll in a local Intensive Outpatient Program (IOP) while on leave.

CONTROLLED MEDICATIONS

1. Stimulants (C-II medications) generally require an appointment to receive a refill. These prescriptions have an expiration of 21 days, including transit time and processing at mail-order pharmacies. Once filled, we suggest picking up your prescription when available to avoid expiration.
2. If a prescription or med bottle is lost, expired, or the dose increased, an appointment may be required to monitor compliance and medical necessity before a new prescription is issued.
3. C-11 medications require follow-up visits every three months.
4. The State of Texas mandates that a PDMP database be consulted and examined by your provider before any controlled medication refill request is granted.

AFTER-HOURS RESOURCES

1. Services by the clinician will be provided to the patient within normal business hours.
2. For assistance after-hours, we have a nurse on call who can be reached by calling **800-544-6444**
3. In case of an emergency, call 911 (for medical or psychiatric emergencies), 472-HELP (suicide hotline for Travis Co.), or may go to a local Emergency Room or psychiatric hospital (or a combination of the above.) Please see our website for more Resources at centexmh.com
4. Psych Hospitals: Rock Springs Hospital (512) 819-9400 Seton Psychiatric ER (512) 324-7259
5. Urgent Care Centers (Nextcare etc.) can be a resource for short-term refills (bring your empty bottle) and Pharmacies can dispense a 3-day (a.k.a. "loaner") supply at their discretion.

COMPLIANCE

1. It is our hope and expectation that patients are motivated to improve their mental health. It is the responsibility of patients to comply with agreed-upon treatment plans and recommendations from the clinician (treatment alliance and therapeutic relationship)
2. Our office uses RightSignature to administer paperwork, diagnostic tools, and forms necessary for the administration and is a vital aid in your treatment. You have the right to refuse this (and any other treatment) however it may be considered noncompliance with medical recommendations.

3. Repeated instances of non-compliance (failure to get labs, failure to pay your balance, failure to follow-up with therapists, self-medicating, and others) will be considered potentially hazardous and a violation of office policy.
4. Our providers may administer oral/blood/urine drug screening to monitor compliance and appropriateness of certain medications. Consent is voluntary, but refusal may limit medication options your provider can prescribe.
5. Treatment is based on the informed consent of the patient. If you have any questions or concerns regarding medications or other aspects of treatment, please query your provider. Do not consent to any medication or other intervention before considering yourself adequately informed.

BEHAVIOR

1. We understand that patients experience many difficulties as a result of mental health problems or other circumstances, and we strive to provide the best outpatient service for our patients. However, if at any point staff or clinicians feel threatened by an individual, this may be cause for immediate termination of our professional relationship.
2. Threatening behavior includes (but is not limited to) direct or indirect threats towards staff or other patients, lewd behavior, verbal abuse, yelling, or physically damaging property. Please be civil at all times.
3. Deliberately misleading staff or clinicians may be grounds for termination of our professional relationship, depending on the circumstance.

CONFIDENTIALITY

1. The clinic understands the need to keep your matters confidential, and we will act in good faith to keep your matters private. Please use caution in leaving us home or work numbers to call you back, as leaving a message or conversing there may jeopardize your confidentiality.
2. Staff or physicians may require a release to speak to family members or other providers unless the clinic believes in good faith there is an emergency, and it serves your best interests (principle of beneficence).
3. Please ask the receptionist for releases for anyone you would like to have access to your information ahead of time. Review and update your Release form at least annually as well as your Contact Information.
4. Certain 3rd party payers, labs, courts, and other entities industry may need access to some of your protected health information (PHI). Please see the HIPAA statement. While patient confidentiality is protected and highly valued, exceptions to physician-patient confidentiality do exist under state and federal law.

ADDITIONAL FEES

Emotional Support Animal Letter (per animal): **$15.00**
Medical Records: **$25.00**

Severe or repeated violations of office policy may result in a discontinuation of our professional relationship. If the patient doubts the validity of the violation, he/she can contact our office to discuss it. You reserve the right to end our professional relationship at any time. We look forward to serving you!

This Guide for Office Policies was last updated on 12/28/2023 and may be updated in the future without notice; however, a current copy can be requested at our office, by mail or fax, free of charge. If any policy conflicts with state, local, or federal law, that policy or portion of that policy will be considered null and void. Central Texas Mental Health is a DBA ("doing business as") of Round Rock Mental Health PLLC, formerly known as Round Rock Mental Health PA.

NOTICE OF PRIVACY PRACTICES

YOUR RIGHTS:

Get an electronic or paper copy of your medical record: a) You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. b) We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: a) You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. b) We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: a) You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. b) We will say "yes" to all reasonable requests.

Ask us to limit what we use or share: a) You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. b) If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information: a) You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. b) We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: a) You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: a) If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: a) You can file a complaint if you feel we have violated your rights by contacting the office b) You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** c) We will not retaliate against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: a) Share information with your family, close friends, or others involved in your care and b) Share information in a disaster relief situation Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: 1) Marketing purposes **2)** Sale of your information

OUR USES AND DISCLOSURES: How do we typically use or share your health information? We typically use or share your health information in the following ways: **1) Treat you.** We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.* **2) Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.* **3) Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? a) We are allowed or sometimes required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. b) **Help with public health and safety issues**. We can share health information about you for certain situations such as: Preventing disease / Helping with product recalls / Reporting adverse reactions to medications /Reporting suspected abuse, neglect, or domestic violence and preventing or reducing a serious threat to anyone's health or safety. c) **Do research-** We can use or share your information for health research. **d) Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. e) **Respond to organ and tissue donation requests -**We can share health information about you with organ procurement organizations. f) **Work with a medical examiner or funeral director;** We can share health information with a coroner, medical examiner, or funeral director when an individual dies. Address workers' compensation, law enforcement, and other government requests. g) **We can use or share health information about you:** For workers' compensation claims, For law enforcement purposes or with a law enforcement official, With health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services. h) **Respond to lawsuits and legal actions**: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES:

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. **Changes to the Terms of this Notice -** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

CONTROLLED SUBSTANCES THERAPY AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and protect our ability to prescribe to you. Certain medications for concentration, anxiety, and sleep have the potential for abuse or diversion.

Accountability is necessary as per governing bodies. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the providers at CTMH to consider the initial and/or continued prescription of controlled substances to treat your mental health diagnoses.

1. All controlled substances in a class should be prescribed from the same medical practice.
2. All controlled substances should be obtained at the same pharmacy, when possible.
3. You are expected to be proactive and inform our office of any new, recent or current controlled medications prescribed or non-prescribed. This applies to recreational and/or illegal substances.
4. The prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacies and other professionals who provide your health care. This includes accessing physical and electronic medicine prescription histories online.
5. You may not share, sell, or otherwise permit others to have access to these medications. Care for the safety of your medication and always keep it in the original container from the pharmacy.
6. These medications should not be stopped abruptly, as abstinence syndrome may develop.
7. Initial or subsequent oral, urine, or blood toxicology may be requested, and your cooperation may be required for ongoing treatment with certain controlled medications. Consuming illegal or nonprescribed substances (aka “street drugs”) may be grounds for discontinuing controlled substances and/or discontinuing our professional relationship.
8. Early refills may not be approved. Please discuss with your office any extenuating circumstances.
9. Refills are contingent upon scheduling and keeping regular appointments.
10. It is understood that non-adherence to these policies may result in cessation of therapy with the controlled medication and potentially your therapeutic relationship with our practices.

TELEMEDICINE INFORMED CONSENT

Purpose: The purpose and use of telemedicine at Central Texas Mental Health ("CTMH") is to provide real-time consultation, evaluation, diagnosis, and treatment of a mental health condition using advanced telecommunications technology. The technology uses an interactive two-way audio and video communication link-up whereby the physician and/or mental health care provider can see, hear and communicate with the patient in real-time. Telemedicine benefits include increased accessibility to mental healthcare and patient convenience.

Service Provider: Central Texas Mental Health's telemedicine service provider is Doxy.me, LLC. The interactive electronic systems used by Doxy.me incorporate network and software security protocols to safeguard the data and protect the confidentiality of patient information and audio/visual data.

Consent for Treatment: I consent to and voluntarily agree that my CTMH physician or CTMH physician assistants, (collectively, "telemedicine provider"), may utilize telemedicine to provide me with and/or assist in the delivery of my mental health services.

In giving my informed consent, I acknowledge and agree to the following:

- I understand that my telemedicine provider: (i) practices in a different location than where I present for mental health care; (ii) does not have the opportunity to meet with me face-to-face to perform an in-person assessment, except through audio-video conference only; and, (3) relies on information provided by me.
- I understand that I must be physically within Texas to be eligible for CTMH telemedicine. I understand that my telemedicine provider can send medication prescriptions to Texas pharmacies only.
- I understand that my telemedicine provider cannot be responsible for advice, recommendations, and/or decisions based on incomplete or inaccurate information provided by me, the patient, or others. I acknowledge that it is my responsibility to provide information about my mental health history, medical history, condition and care that is complete and accurate to the best of my ability.
- I understand that I may not record any telemedicine session without written consent from Central Texas Mental Health.
- I will inform my telemedicine provider as soon as my session begins if any other person can hear or see any part of our session.
- I understand that if I experience an urgent medical matter after the telemedicine session, I should alert my treating physician, and in the case of an emergency dial 9-1-1, or go to the nearest hospital emergency department.
- I understand I can ask questions and seek clarification of the procedures and telemedicine technology.
- I understand that I can ask that the evaluation and/or video conference be stopped at any time.
- I know there are potential risks with the use of technology. These include but are not limited to:
  - Interruption of the audio/video link
  - Disconnection of the audio/video link
  - A picture that is not clear enough to meet the needs of the consultation
  - Delays in psychiatric evaluation and treatment due to equipment failure or deficiency

- I understand and agree that my electronic device must have a working camera and audio input so that my telemedicine provider can see and hear me in real time. I agree to ensure proper functioning of my electronic device prior to my session.
- I understand and agree that if I lose my connection during a session, I will immediately attempt to log back into the http://Doxy.me "waiting room". If the audio I am receiving during a telemedicine session is not complete and clear, I will attempt to let my telemedicine provider know or telephone CTMH to schedule a new appointment.
- In the event the telemedicine session is interrupted, disconnected or does not meet the needs of the consultation due to a technological problem or equipment failure, alternative means of communication (i.e. telephone) may be implemented or an in-person mental health evaluation may be necessary.
- I understand that if anyone other than my telemedicine provider is present during my telemedicine session, that I will be informed of their presence and will have the right to request that any non-medical personnel leave the telemedicine session or I may terminate the consultation at any time.
- I understand that I have the right to withdraw my consent to the use of telemedicine at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment from my CTMH physician or physician assistant.
- I understand that my CTMH physician or physician assistant has the right to withhold or withdraw his/her consent to the use of telemedicine at any time during the course of my care.
- I acknowledge that I have been provided with written notification of Central Texas Mental Health's telemedicine privacy practices.

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling **1-800-201-9353**. For more information please visit the Texas Medical Board website at: www.tmb.state.tx.us

I have read and understand the information provided above regarding telemedicine. I have had an opportunity to discuss and ask questions regarding the risks, benefits, and practical alternatives to telemedicine with my CTMH physician or physician assistant. I hereby give my informed consent and authorize my Central Texas Mental Health physician and/or physician assistants to use telemedicine in the course of my mental health care, evaluation, diagnosis, and treatment.

Printed Name Date

Signature of Patient (or parent, legal guardian, or conservator) Relationship to Patient

Surprise Medical Bills – Your Rights and Protections

The No Surprises Act, 2021& Texas Senate Bill 1264 (SB 1264), 2019

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

"Balance billing" means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan. Amounts charged are likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services.

A. You're protected from balance billing for:
    1) Emergency services: If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
    2) Texas citizens covered by state-regulated PPO, EPO, HMO and Employee Retirement System/Teacher Retirement System plans and certain nonprofit agricultural organizations. Balance billing is prohibited for amounts due beyond cost sharing amounts for:
        i. Emergency care,
        ii. Care provided at an in-network facility by an out of network provider, and
        iii. Labs & imaging (in connection with in-network care)
    3) Certain services at an in-network hospital or ambulatory surgical center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount.
        i. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.
        ii. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.
        iii. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

B. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

C. SB 1264 prohibits balance billing to health benefit plan enrollees, expands the Texas Department of Insurance (TDI) mediation program between health benefit plans and out-of-network facilities, creates an arbitration system between health benefit plans and out-of-network providers that are not facilities, and requires health plans to cover certain out-of-network services at the usual and customary rate.
    1) An out-of-network provider or a health benefit plan issuer or administrator may request mediation of a settlement of an out-of-network health benefit claim through a portal on the department's Internet website if:
        i. there is an amount billed by the provider and unpaid by the issuer or administrator after copayments, deductibles, and coinsurance for which an enrollee may not be billed; and
        ii. the health benefit claim is for:
            a. emergency care;
            b. an out-of-network laboratory service; or
            c. an out-of-network diagnostic imaging service.

D. When balance billing isn't allowed, you also have these protections:
    1) You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
    2) Generally, your health plan must:
        i. Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
        ii. Cover emergency services by out-of-network providers.
        iii. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
        iv. Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

➲ If you think you've been wrongly billed, contact 1-800-252-3439 (Texas Department of Insurance).

➲ Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law and you may also visit www.tdi.texas.gov/consumer/health-insurance.html for more information about your rights as a citizen of Texas.

MDQ

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and…		
...felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
…you were so irritable that you shouted at people or started fights or arguments?		
…you felt much more self-confident than usual?		
…you got much less sleep than usual and found you didn't really miss it?		
…you were much more talkative or spoke much faster than usual?		
…thoughts raced through your head or you couldn't slow your mind down?		
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
…you had much more energy than usual?		
…you were much more active or did many more things than usual?		
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
…you were much more interested in sex than usual?		
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
…spending money got you or your family into trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		
3. How much of a problem did any of these cause you--like being unable to work; having family, money or legal troubles; getting into arguments or fights? No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
5. Has a health professional every told you that you have manic-depressive illness or bipolar disorder?		

MDQ

Score_____

Date

Patient

PHQ-9

Instructions: Over the last 2 weeks, how often have you been bothered by any of the following?		Not at all	Several days	Over half	Nearly everyday
1	Little interest or pleasure in doing things.	0	1	2	3
2	Feeling down, depressed, or hopeless.	0	1	2	3
3	Trouble falling asleep, or sleeping too much.	0	1	2	3
4	Feeling tired or having little energy.	0	1	2	3
5	Poor appetite or overeating.	0	1	2	3
6	Feeling bad about yourself- or that you are a failure or have let yourself or your family down.	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

_____ _____ _____

10 How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

11 Would you be interested in learning more about safe, effective, non-drug treatments for depression?

12 Do you have any history of the following:

a. Seizures or epilepsy?
b. Psychosis

13 What types of therapy/counseling have you had in the past?

a. When/how old were you when you attended therapy?
b. What was the name of your therapist(s)? (Name, LCSW, LMFT, PhD, etc)

PHQ-9
Score_____

Date
Patient

Please select any medications you have tried.				
CELEXA Citalopram	LEXAPRO Escitalopram	PROZAC Fluoxetine	PAXIL Paroxetine	ZOLOFT Sertraline
LUVOX Fluvoxamine	PRISTIQ Desvenlafaxine	CYMBALTA Duloxetine	EFFEXOR Venlafaxine	SAVELLA Milnacipran
FETZIMA Levomilnacipran	WELLBUTRIN Bupropion	REMERON Mirtazapine	SERZONE Nefazodone	DESRYEL Trazodone
VIIBRYD Vilazodone	TRINTELLIX Vortioxetine	SPRAVATO Esketamine	ELAVIL Amitriptyline	NORPRAMIN Desipramine
SILENOR Doxepin	TOFRANIL Imipramine	PAMELOR Nortriptyline	ASCENDIN Amoxapine	ANAFRANIL Clomipramine
LUDIOMIL Maprotiline	SURMONTIL Trimipramine	VIVACTIL Protriptyline	NARDIL Phenelzine	EMSAM Selegiline
PARNATE Tranylcypromine	ABILIFY Aripiprazole	REXULTI Brexpiprazole	SEROQUEL Quetiapine	RISPERDAL Risperidone
GEODON Ziprasidone	ZYPREXA Olanzapine	LITHIUM	LAMICTAL Lamotrigine	TOPAMAX Tompiramate
T3 Triiodothyronine	DEPIN L-methylfplate	LATUDA Lurasidone	INVEGA paliperidone	SAPHRIS asenapine
VRAYLAR cariprazine	STRATERRA atomoxetine	INDERAL propanolol	DEPAKOTE Divalproex	HALDOL Haloperidol

GAD-7

Instructions: Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	Over half	Nearly everyday
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

_____ _____ _____

Score / 21 Date

GAD-7
Score_____

Date
Patient

BSDS

1. Please read through the entire passage below before filling in any blanks.

Some individuals notice that their mood and/or energy levels shift drastically from time to time___. These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high___. During their "low" phases, these individuals often feel a lack of energy; a need to stay in bed or get extra sleep; and little or no motivation to do things they need to do___. They often put on weight during these periods___. During their low phases, these individuals often feel "blue", sad all the time, or depressed___. Sometimes, during these low phases, they feel hopeless or even suicidal___. Their ability to function at work or socially is impaired___. Typically, these low phases last for a few weeks, but sometimes they last only a few days___. Individuals with this type of pattern may experience a period of "normal" mood in between mood swings, during which their mood and energy level feels "right" and their ability to function is not disturbed___. They may then notice a marked shift or "switch" in the way they feel___. Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do___. Sometimes, during these "high" periods, these individuals feel as if they have too much energy or feel "hyper"___. Some individuals, during these high periods, may feel irritable, "on edge", or aggressive___. Some individuals, during these high periods, take on too many activities at once___. During these high periods, some individuals may spend money in ways that cause them trouble___. They may be more talkative, outgoing, or sexual during these periods___. Sometimes, their behavior during these high periods seems strange or annoying to others___. Sometimes, these individuals get into difficulty with co-workers or the police, during these high periods___. Sometimes, they increase their alcohol or non-prescription drug use during these high periods___.

2. Now that you have read this passage, please check one of the following four boxes:

- ☐ This story fits me very well, or almost perfectly
- ☐ This story fits me fairly well
- ☐ This story fits me to some degree, but not in most respects
- ☐ This story does not really describe me at all

3. Now please go back and put a check after each sentence that definitely describes you.

BSDS
Score_____

Date
Patient

SABC

Instructions: *Please answer the following questions regarding an important safety matter.*

1. Have you ever thought about or attempted to kill yourself?

Never	It was a brief passing thought	I have had a plan at least once to kill myself but did not try to do it	I have attempted to kill myself, but did not want to die	I have had a plan at least once to kill myself and really wanted to die	I have attempted to kill myself, and really wanted to die
0	1	2	3	4	5

2. How often have you thought about killing yourself in the past year?

Never					Very Often
0	1	2	3	4	5

3. In the past year, have you had an internal debate/argument (in your head) about whether to live or die?

Never					Frequently
0	1	2	3	4	5

4. Right now, how much do you wish to live?

Very Much					Not at all
0	1	2	3	4	5

5. Right now, how much do you wish to die?

Not at all						Very Much
0	1	2	3	4	5	6	7

6. How likely is it that you will attempt suicide someday?

Not at all					Very Likely
0	1	2	3	4	5

If you have selected any number in the shaded areas above, complete the Safety Plan on the following page ==>

SAFETY PLAN WORKSHEET

1 **Warning Signs** of a developing crisis *(i.e. thoughts, images, mood, situation, behavior)*

_____

_____

_____

2 Internal **Coping Strategies** — things I can do to distract my mind when I am alone *(relaxation technique, physical activity)*

_____

_____

_____

3 **Places, People, Social Settings** to provide further distraction

Place 1 _____

Place 2 _____

4 **People** whom I can ask for help

Name_____

Phone_____

Name_____

Phone_____

Name_____

Phone_____

Name_____

Phone_____

5 **Professionals** or agencies to contact in crisis

EMERGENCY NUMBERS

Central Texas Mental Health

512. 964. 6992

[after hours] 1. 800. 544. 6444

Suicide Hotline

1. 800. 784. 2433

1. 800. 273. TALK (8255)

Compassionate Ear Warmline

1. 866. 927. 6327

6 Make the environment **SAFE**

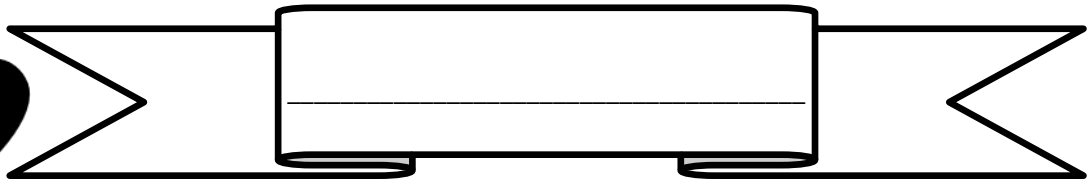
_____

_____

_____

_____

7 The one thing that is most important to me and **worth living for**



_____

AIMS ASSESSMENT

Date
Patient

Have you ever taken any of the antipsychotics or mood stabilizers listed here?

Yes ☐ No ☐

If you answered "No", you may skip the rest of this page.
If you answered "Yes", please finish the questionnaire.

TD MEANS HAVING MOVEMENTS YOU CAN'T CONTROL

Tardive Dyskinesia, or TD is a condition of uncontrollable movements affecting the face, torso, and other body parts.

TD is associated with taking certain medications, such as antipsychotics, for a few months.

Here's a list of questions about uncontrollable movements to discuss.

This questionnaire is not a validated assessment tool, nor is it a diagnostic tool for TD. TD should be be diagnosed by a medical professional.

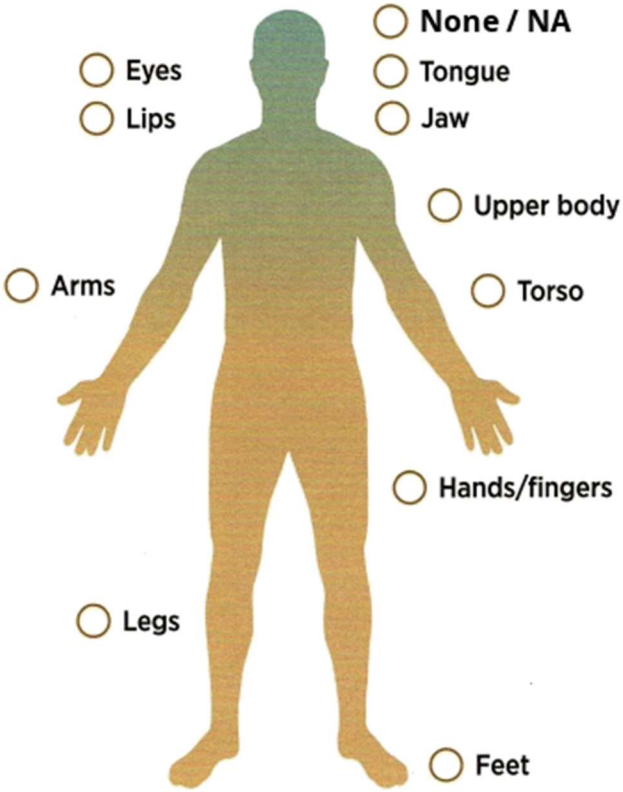
1 Have you ever taken antipsychotic medication(s) to treat any of the following conditions? *(Select all that apply)*

- ☐ Depression
- ☐ Schizophrenia
- ☐ Schizoaffective disorder
- ☐ Bipolar disorder
- ☐ Anxiety
- ☐ Other: _____

antipsychotic medications:

[ ] Abilify	[ ] Vraylar
[ ] Latuda	[ ] Saphris
[ ] Seroquel	[ ] Haldol
[ ] Risperdal	[ ] Fanapt
[ ] Zyprexa	[ ] Invega
[ ] Geodon	[ ] Other

2 Have you experienced uncontrollable movements such as pursing, puckering, blinking, jerking, rocking, or twisting in the: *(Select all that apply)*



3 On a scale of 1 to 5, how bothersome do you find these movements?

- ○ 1: Not noticeable at all
- ○ 2
- ○ 3
- ○ 4
- ○ 5: Extremely bothersome

4 Has anyone ever noticed your movements? If so, who? *(Select all that apply)*

- ☐ Me
- ☐ Spouse
- ☐ Family member
- ☐ Friend/coworker
- ☐ Healthcare provider
- ☐ Other: _____

1717 N Interstate 35, Ste 200
Round Rock, TX 78664
(512) 964-6992

Central Texas Mental Health

Acknowledgment of Receipt of Practice Policies

By my signature, I acknowledge that I have read, understand, and agree to the policies and procedures of treatment as defined in the intake packet I received.

Those policies include:

- ☐ Office Policies
- ☐ Privacy Practices
- ☐ Controlled Substances Therapy Agreement
- ☐ Consent for Telemedicine
- ☐ Surprise Medical Billing

_____ _____

Patient Signature Date