RESTORE BEHAVIORAL HEALTH, PLLC

414 West Sunset Rd, Suite 201 San Antonio, Texas 78209
Phone: (210) 858-1900 Fax: (210) 745-4525

CLIENT INTAKE FORM

(Please Print Clearly)

Today's Date _____/_____/_____

Client's Last Name First Middle	❑Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑M ❑ F

Street Address City State ZIP Code	Social Security - -	Home Phone No. ( )
P.O. Box City State ZIP Code		Cell Phone No. ****REQUIRED**** ( )
Occupation / Employer		Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. _____ ❑Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Email Address	Alternative Email Address

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑No	Total Annual EAPs allowed? _____

Please Select Your Primary Insurance

❑ Amerigroup ❑ Assurant ❑ Beech Street ❑ Blue Cross/Blue Shield ❑ ChoiceCare ❑ Champus
❑ Cigna ❑ Definity Health ❑ First Health ❑ HealthSmart ❑ Humana ❑ Aetna ❑ Medicaid
❑ Medicare ❑ MHN/MHNet ❑ PHCS ❑ PMHS ❑ Texas True Choice ❑ TriCare ❑Unicare
❑ United Healthcare ❑ Value Options ❑ Other _____

What is the authorization number?	❑ Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #

Client's Relationship to Insured ❑Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any) Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Emergency Contact Name ****REQUIRED****	Relationship to Client	Cell Phone No.	Home Phone No.

Please list any previous diagnosis given	Patient's Grade *(If applicable)*

Restore Behavioral Health, PLLC

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

This notice describes how PHI about you may be used and disclosed and how you can access this information. Restore Behavioral Health, PLLC ("Restore", inclusive of Restore Behavioral Health, PLLC and all clinical and administrative staff)) is required by applicable federal and state law to maintain the privacy of your PHI. Restore is also required to give you this notice about its privacy practices, its legal duties, and your rights concerning your Protected Health Information ("PHI"). Restore must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/2003, and will remain in effect until updated, at which time you will receive notice of any changes.

Restore reserves the right to change its privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Restore reserves the right to make the changes in its privacy practices and the new terms of its notice effective for all PHI that Restore maintain, including PHI Restore created or received before Restore made the changes. Before Restore makes a significant change in its privacy practices, Restore will change this notice and make the new notice available upon request. You may request a copy of its notice at any time. For more information about its privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of PHI

Restore uses and discloses PHI about you for treatment, payment, and health care operations. For example:

Treatment: Restore may use your PHI to treat you or disclose your PHI to a physician or other health care provider providing treatment to you. Restore may also use your PHI to conduct quality assurance reviews, case supervision, development of clinical guidelines and treatment outcome studies.

Payment: Restore may use and disclose your PHI to obtain payment for services Restore provides to you.

Health Care Operations: Restore may use and disclose your PHI in connection with its health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation and certification, licensing or credentialing activities.

To you and on Your Authorization: You may give us written authorization to use your PHI or to disclose it to an identified person for a specific purpose. Unless you give us a written authorization, Restore cannot use or disclose your PHI for any reason except those described in this notice. If you give us an authorization to use PHI or any other specific information, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: Restore must disclose your PHI to you, as described in the Individual Rights section of this notice. Restore may disclose your PHI to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care with your authorization and within the confines of state regulations to coordinate emergency care.

Appointment Reminders: Restore may use your PHI to contact you to provide appointment reminders.

Research: Restore may use or disclose your PHI for research purposes in limited circumstances upon your consent and authorization.

Required by Law: Restore may use or disclose your PHI when Restore is required to do so by law. For example, Restore must disclose your PHI to the U.S. Department of Health and Human Services upon request for purposes of determining whether Restore is in compliance with federal privacy laws. Restore may disclose your PHI when authorized by workers' compensation or similar laws. Restore may disclose your PHI to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Law Enforcement: Restore may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Restore will seek your specific written authorization in these situations whenever possible. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, Restore may disclose your PHI to law enforcement officials. Restore may disclose limited information to a law enforcement official concerning the PHI of a suspect, fugitive, material witness, crime victim or missing person. Restore may disclose the PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances.

Abuse, Neglect, or Imminent Harm: Restore may disclose your PHI to appropriate authorities if Restore reasonably believes that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. Restore may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Restore may disclose PHI when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

National Security: Restore may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. Restore may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. Restore may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or individual under certain circumstances.

Individual Rights

Access: You have the right to look at or get copies of your PHI, with limited exceptions. You may request that Restore provide copies in a format other than photocopies. Restore will use the format you request unless Restore cannot practicably do so. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice.

Disclosure Accounting: You have the right to receive a list of instances in which Restore or its business associates disclosed your PHI for purposes, other than treatment, payment, health care operations or pursuant to an authorization and certain other activities, since 5/1/2009. Restore will provide you with the date on which Restore made the disclosure, the name of the person or entity to whom Restore disclosed your PHI, a description of the PHI Restore disclosed, the reason for the disclosure, and certain other information. If you request this accounting more than once in a 12-month period, Restore may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of its fee structure.

***Restrictions*:** You have the right to request that Restore place additional restrictions on its use or disclosure of your PHI. Restore is not required to agree to these additional restrictions, but if Restore does, Restore will abide by its agreement (except in an emergency). Any agreement Restore may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on its behalf. Restore will not be bound unless its agreement is so memorialized in writing.

Confidential Communication: You have the right to request that Restore communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing, and you must state that the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. Restore must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment. You have the right to request that Restore amend your PHI. Your request must be in writing, and it must explain why the information should be amended. Restore may deny your request if Restore did not create the information you want amended and the originator remains available or for certain other reasons. If Restore denies your request, Restore will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If Restore accepts your request to amend the information, Restore will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice electronically, you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about its privacy practices or have questions or concerns, please contact Dr. Melinda Down at 210-858-1900. You also may submit a written complaint to the U.S. Department of Health and Human Services. Restore supports your right to complain and will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

ACKNOWLEGEMENT OF PRIVACY NOTICE

Your acknowledgement of this notice of privacy will be made a part of your medical record. You may request a copy of this notice at any time.

_____

Patient Name (Printed)

_____ _____

Signature of Patient or Legal Guardian Date

PSYCHOLOGICAL SERVICES INFORMED CONSENT

Please read the information below so that you can provide your Informed Consent for psychological assessment and treatment services at Restore Behavioral Health, PLLC (RBH). Please discuss any questions regarding this Consent with your clinician prior to initiating services.

Psychological Services: Services include Diagnostic Assessments, Psychological Testing, Individual, Family, Marital and Group Psychotherapy, Crisis Intervention, Professional and Organizational Consultation, Psycho educational Training/Coaching, and Didactic presentations. Psychotherapy requires active participation from the client and may involve increased awareness into emotions of sadness, anger, or anxiety.

Hours and Session Duration: Hours of Operation are from 9:00am to 6:00pm Monday through Friday. Saturday appointments may also be available. Therapy sessions will typically last 45 minutes, although there may be instances that require a shorter or longer visit.

Fees and Managed Care: RBH will verify your health plan insurance eligibility for mental health and substance abuse benefit coverage. Most insurances are accepted. however you are responsible for services not covered by your insurance company. For evening & Saturday visits, a credit card must be kept on file for automatic Co Pay processing. RBH is on several managed care panels and accepts health insurance reimbursement under these specific Provider Agreements. The **Fee-For-Service** rates are listed below:

Service	Ph.D. Rate	Master's Rate (LPC, LCSW)	Service	Ph.D. Rate	Master's Rate (LPC, LCSW)
Diagnostic Intake Appointment:	$190	$155	Individual Psychotherapy Extended/Crisis (60-70 min.)	$155	$130
Brief Psychotherapy (20-25 min.)	$75	$50	Psychological & Neuropsychological Testing:	$135 / hr	N/A
Individual Psychotherapy (45-50 min.)	$135	$105	Pre-Surgical Psychological Evaluation	$460	N/A
Family Psychotherapy (45-50 min)	$150	$125	Neurobehavioral Status Exam:	$105	N/A
Group Psychotherapy (45-50 min)	$60	$45	Telephonic or Correspondence (emails, letters, forms, etc) Consultation	$20 per 10 min	$15 per 10 min
Health and Behavior Assessments	$130/hr	N/A	Health and Behavior Interventions	$60 -30 min $110 – 60 min	N/A

Cancellation Policy: Patients are asked to keep their appointments, as this time as been specifically reserved for you. Please notify the office of any need to cancel your appointment with 24 hours notice in order to avoid the cancellation fee.

*$75 Cancellation Fee - All Testing Appointments

*$45 Cancellation Fee - (Mon.-Sat.) Therapy Appointments

*** ***If there are three or more cancellations, we will be unable to accommodate scheduling recurring appointments; Scheduling an appointment can be made available on a waiting list /call in basis. ****

Confidentiality: All records will be kept confidential and will be held in accordance with the state and federal regulations regarding the confidentiality of such records and Personal Health Information. Privileged information will only be released upon the client's written authorization. The following are exceptions to the privilege of confidentiality:

1) All situations involving abuse or neglect, or suspicion thereof, of a child or elderly person must be reported to the appropriate protective agency.
2) If there is an imminent danger of harm to self or others, information may be released to the medical and/or law enforcement personnel for the coordination of emergency care.
3) Records must be released in accordance with any court proceedings, subpoenas, qualified audits, program evaluations or investigations authorized by state or federal regulations. *RBH does **NOT** accept court-related cases or conduct custody evaluation & can provide a referral for these cases.*

Release of Information: RBH may release information with your consent for the reasons noted on your signed HIPAA notice. RBH may be required to release information regarding your assessment and/or treatment with your insurance company pertaining to authorization or medical necessity determinations. Clinical case information may be communicated to other health care professionals for the purposes of consultation and/or training, and such communications will be bound by the same professional and ethical guidelines regarding confidentiality. Releasing information to another health care professional or family member for the purpose of coordination of care will take place only with your specific authorization.

Emergency/On-Call Services: In the event of an emergency after hours please call 9-1-1- or proceed to the nearest hospital. Restore Behavioral Health does NOT offer after hour's on-call services.

Access of Records: The laws and standards of the profession of psychology require maintenance of treatment records. Adult clients and legal guardians or minors, including managing and possessory conservators, have the right to access the record of the services provided to them or their child. If such access is determined to be of potential harm to a client, the information will instead be summarized or shared directly with an authorized health care professional.

Treatment of a Minor: Treatment of children under the age of 18 will be provided with the consent of the Parent or Legal Guardian. For divorced parents, managing conservators are required to provide consent for treatment of the minor. A copy of the divorce decree or court order designating conservatorship is required at the time of intake. In some emergency situations, a minor may consent to his/her own treatment.

I have read and understand this statement of informed consent. I voluntarily consent to treatment at Restore Behavioral Health with the knowledge of the above conditions.

_____

Patient Name (Printed)

_____ _____

Patient/Legal Guardian/Managing Conservator Signature Date

Restore Behavioral Health, PLLC

QEEG & NEUROFEEDBACK SERVICES INFORMED CONSENT

Please read the information below so that you can provide your Informed Consent for QEEG and Neurofeedback services at Restore Behavioral Health, PLLC ("Restore"). Please discuss any questions regarding this Consent with your clinician prior to initiating services.

QEEG Services: Services include a 19-channel Quantitative Encephalogram analysis and "Brain Map" report. The procedure entails wearing an electrocap with 19 sensors that record the electrical activity across different regions of the brain. Your brain wave patterns will be statistically compared to a normative database. Neurofeedback treatment protocols will be established based on the findings of your QEEG. The client must follow a few preparation procedures and be able to sit still for an eyes open and eyes closed recording. Cases involving Seizures or possible Traumatic Brain Injury will require a Neurology consult.

Neurofeedback Services: Neurofeedback, or EEG biofeedback, sessions may be recommended to help the brain regulate its neurophysiological functioning. Your clinician will place one or more sensors on your scalp and your brain wave activity will be monitored. Feedback in the form of auditory "beeps" and/or visual feedback (e.g. DVD, computer game) will be provided based on the operant conditioning model of reinforcement and inhibition. Success depends on client's regular commitment to attending sessions and practicing any recommended homework. Neurofeedback is generally considered a safe, non-invasive alternative intervention. However, some clients can experience heightened sensitivity to medications and adjustments may need to be made under your physician's supervision. Neurofeedback is an approved relaxation method only and is considered experimental for other uses. It may alter mood, mental clarity, sleep/wake cycle, sense of calm. Memories of past trauma may be triggered. Those with a substance addiction may become allergic to the substance. Training may help facilitate neurophysiological change but is not a substitute for medication.

Hours and Session Duration: Hours of Operation are from 9:00am to 6:00pm Monday through Friday. Saturday morning appointments may also be available. The QEEG will take about 1 hour and Neurofeedback sessions generally last 30-minutes.

Fees and Managed Care: Restore Behavioral Health, PLLC will verify your health plan insurance eligibility for mental health and substance abuse benefit coverage. Your insurance company will be billed as a convenience to you, however you are responsible for services not covered by your insurance company. Unfortunately, many insurance companies do not cover QEEG and Neurofeedback services. When covered, Restore Behavioral Health is on a number of managed care panels and accepts the rate of reimbursement under these specific Provider Agreements. The fees qualify for Health Savings Account expenses. The fee-for-service rates are listed below:

Fee-for-Service Rates:		Neurofeedback 30 Min Session:	$95.00
QEEG Brain Map:	$625.00	Neurofeedback 45 Min Session:	$142.50
Follow-Up QEEG (after 20-40 sessions)	$400.00	Package of 20 NFB 30 min sessions ($85 each):	$1,700.00
Telephonic Consultations:	$85.00 per hour	Package of 40 NFB 30 min sessions ($75 each):	$3,000.00
Neurology Consultation:	$250.00	Package of 60 NFB 30 min sessions ($65 each):	$3,900.00
Court Cases	$250 per hour, following $2000 retainer	Package of 20 NFB 45 min sessions ($112.50 each):	$2,250.00

Cancellation Policy: Patients are asked to keep their appointments, as this time as been specifically reserved for you. Please notify the office of any need to cancel your appointment with 24 hours notice in order to avoid the $25 cancellation fee, $75 for testing appts. Prepaid Neurofeedback packages and sessions presume a commitment from the patient. Refunds for any unused sessions will not be processed.

Confidentiality: All records will be kept confidential and will be held in accordance with the state and federal regulations regarding the confidentiality of such records and Personal Health Information. Privileged information will only be released upon the client's written authorization. The following are exceptions to the privilege of confidentiality:

1) All situations involving abuse or neglect, or the suspicion thereof, of a child or elderly person must be reported to the appropriate protective agency.
2) If there is an imminent danger of harm to self or others, information may be released to the medical and/or law enforcement personnel for the coordination of emergency care.
3) Records must be released in accordance with any court proceedings, subpoenas, qualified audits, program evaluations or investigations authorized by state or federal regulations.

Release of Information: Restore may release information with your consent for the reasons noted on your signed HIPAA notice. Restore be required to release information regarding your assessment and/or treatment with your insurance company in order to receive reimbursement for services provided. Clinical case information may be communicated to other health care professionals for the purposes of consultation and/or training, and such communications will be bound by the same professional and ethical guidelines regarding confidentiality. Releasing information to another health care professional or family member for the purpose of coordination of care will take place only with your specific authorization.

Emergency/On-Call Services: In the event of an emergency after hours, please proceed to the nearest hospital. Restore also offers 24 hour emergency on-call services for telephonic consultation.

Access of Records: The laws and standards of the profession of psychology require maintenance of treatment records. Adult clients and legal guardians or minors, including managing and possessory conservators, have the right to access the record of the services provided to them or their child. If such access is determined to be of potential harm to a client, the information will instead be summarized or shared directly with an authorized health care professional.

Treatment of a Minor: Treatment of children under the age of 18 will be provided with the consent of the Legal Guardian. In some emergency situations, a minor may consent to his/her own treatment.

I have read and understand this statement of informed consent. I agree to hold Restore Behavioral Health and its clinicians harmless for any consequences related to the services described herein. I voluntarily consent to treatment at Restore Behavioral Health with the knowledge of the above conditions.

_____
Client Name

_____ _____
Client or Legal Guardian Signature Date

RBH CONSENT FOR TREATMENT OF A MINOR

Patient Name (Child/Minor): _____
Patient DOB: _____
Date of Intake: _____
Are biological parents ____Married ____Separated ____Divorced ____Never Together
Who does the child live with the majority of the time? _____Mom _____Dad _____Other Family Member
Are their regular visits with the non-custodial parent? ____Yes ____No
Are biological parents both actively involved in Minor's life? ____Yes ___No If No, please explain:

_____
_____

Are biological parents both in support of Minor receiving psychological evaluation and treatment services at RBH?
____Yes ___No If No, please explain:

_____
_____

If Divorced or Separated,

1. Who is the Managing Conservator?
   ____Mother ___Father ___Joint ___Other Legal Guardian: _____
2. Are there any step-parents who have been given authority by the court to consent for treatment of the minor? ____Yes ____No If Yes, who: _____
3. Have you provided to RBH a copy of the Court Order/Divorce Decree? ____Yes ____No (Please provide at time of intake)

Has there been a court order designating a Legal Guardian or A Power of Attorney for Health Care Decisions?
____Yes ____No If Yes, who is Legal Guardian/Power of Attorney: _____
_____

Texas law provides that, unless limited by a court order, a parent appointed as conservator (managing or possessory) of a minor has, at all times, the following rights:

a. The right of access to medical, dental, psychological, and educational records of a minor;
b. The right to consult with a physician, dentist, or psychologist of the minor;
c. The right to be designated on the minor's records as a person to be notified in case of emergency; and,
d. The right to give consent for any emergency health care, including surgical procedures.

Sole or joint managing conservator parent(s) have all the rights listed above and may give consent for a minor's non-emergency invasive surgical procedure and may consent to psychological or psychiatric treatment of a minor, unless limited by a court order.

Non-Parent Conservators a. Non-Parent Sole Managing Conservator: Non-parent sole managing conservators have the right to provide consent for the minor to receive medical, psychiatric, psychological, dental, and surgical treatment and to have access to the minor's medical record.

A minor may provide consent for medical, dental, psychological and surgical treatment of the minor if the minor:

1. Is on active duty with the armed services of the United States of America;
2. Is 16 years of age or older and resides separate and apart from his or her parents, managing conservator, or guardian, and, is managing his or her own financial affairs,
3. Consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use; or emergency psychiatric or psychological services

Philosophy of Care: RBH believes that children and minors suffer when the parents are not in agreement when it comes to making decisions about providing psychological evaluation and treatment services. RBH does not get involved in disputes between parents encourages cooperative involvement from both parents in the treatment planning for the minor. RBH believes that psychological treatment for a child should be offered to support the child's optimal well-being and functioning. It is best for families to reach consensus on the goal of seeking evaluation or therapy services for their child or minor. Parents agree to provide the required documentation of conservatorship detailing parental rights and to refrain from utilizing the child's treatment at RBH as part of any dispute between the parents.

My signature below certifies that the information conveyed herein is an accurate reflection of the court-ordered designations for conservatorship of the minor listed above. Note: The Managing Conservator/Custodial Parent must sign all consent forms for the evaluation and treatment of the minor.

_____ _____
Signature of Parent/Legal Guardian/Managing Conservator Date

RBH PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Restore Behavioral Health (RBH) for your behavioral health needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care. If your service is a covered benefit under your health plan and if RBH is in network with your health plan, then we will seek any required authorizations from your insurance company and will bill your insurance on your behalf. RBH agrees to accept the contracted rate for services as designated by each insurance plan and does not balance bill. Fee-For-Service rates are collected for any non-covered or out-of-network services.

- Prior to service delivery, the patient is required to provide the most correct and updated information regarding primary and secondary health insurance coverage, with timely notification of any changes to health insurance plan. Patients are responsible for filing their own claims for any out-of-network or non-covered services.

- Patients are responsible for payment of copays, coinsurance and deductible payments, and fees for all services at the time of service delivery. Patients are financially responsible for any services not covered by their health insurance plan (e.g. beyond the scope of covered benefits, plan considers services not medically necessary, services are beyond plan's visit limitation, insurance plan does not cover services after providing prior authorization or after indicating that no authorization is required).

- It is the patient's responsibility to understand the benefits and limitations under his/her health insurance plan. As a courtesy to our patients, RBH will seek initial benefit eligibility and verification information, however it is the patient's ultimate responsibility to ensure that the benefit information communicated to RBH is accurate, providing updates to RBH with any health plan changes or as insurance deductibles are met. Patients are advised to contact their health insurance plan with any questions regarding the specific benefit information or authorization process for their plan.

- Patients may incur, and are responsible for payment of any additional charges, if applicable. These charges may include:

    - No Show/ Late Cancellation fees (less than 24 hours)
        - $45.00 for therapy, test results, neurofeedback, HBI;
        - $75.00 for testing and QEEG appointments;
    - Returned Checks – Insufficient Funds - $30.00 charge

- Patient Statements will be mailed monthly for any outstanding balances. Payments for invoices are due within 30 days of receipt.

By my signature below, I hereby authorize assignment of financial benefits directly to Restore Behavioral Health for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name _____

Patient/Guardian Signature _____ Date: _____

Restore Behavioral Health, PLLC

NON COURT-RELATED SERVICES CONSENT

I, _____, do hereby consent to seek services at Restore Behavioral Health *for myself / my child / my disabled parent* **(circle one)**, being fully aware that **Restore Behavioral Health, and its full staff, do NOT provide Court-Related Psychological Services**.

I understand that all RBH evaluations are conducted for diagnostic and treatment purposes only and are not intended to be used in legal disputes, including but not limited to child custody cases, employer/employee disputes and/or competency evaluations.

I understand that the treatment services provided at RBH will be provided toward the sole goal of improving the well-being of myself and/or my family member and are not intended to be used in legal disputes, including but not limited to child custody cases, employer/employee disputes, and/or competency evaluations.

I understand that in the case of seeking services for a child in which the parents are divorced, that the Managing Conservator is required to sign all consent forms and agree to provide documentation supporting his/her legal authority to consent for treatment (e.g. Copy of the Divorce Decree). The Managing Conservator understands that the Possessory Conservator has a legal right to access treatment records.

In cases in which there is a Healthcare Power of Attorney, documentation must be provided to support the legal authority to consent for services.

I agree to notify RBH at any time in the course of treatment should a legal case arises that may involve psychological services, so that I may receive an immediate referral to a Forensically-Trained Psychologist.

I understand that RBH is not contracted with any agency for the provision of Court-Ordered Psychological Services.

I understand that RBH does not get involved with disputes/charges against agencies, schools, or organizations.

I understand that RBH will provide a referral for Court-Related Psychological Services should I wish to involve psychological testimony, recommendations, and/or records in any legal case/dispute.

I agree to refrain from involving RBH and any of its staff in any court-related manner, whatsoever.

My signature below indicates my full understanding and compliance with the terms above. I commit that my reason for seeking psychological services at RBH is not legal or Court-Related in any way.

_____ _____

Patient or Legal Guardian Signature Date

This form is mandatory to complete.

Restore Behavioral Health, PLLC

PATIENT NAME: _____

PATIENT CANCELLATION/NO-SHOW POLICY

In an effort to minimize waiting periods and improve appointment availability we have found it necessary to enact a Patient Cancellation Policy. Any patient that cancels an appointment with less than 24 hour notice and/or does not show up for their appointment will have their credit card on file automatically charged a fee of $75 for Testing Visits, and $45 for all other missed appointments. After 3 cancelled appointments, we will be unable to accommodate schedule requests. We hope this policy will ultimately benefit all patients by improving the quality of your treatment experience.

I understand Restore Behavioral Health's cancellation policy.

_____ _____

Signature Date

CREDIT CARD ON FILE: Billing Authorization

The undersigned agrees and authorizes Restore Behavioral Health, PLLC to charge the credit card indicated below for collection of patient responsibility for appointments scheduled after-hours and to auto-process deductible/co-insurance/co-pays, late cancellation and no-show fees.

Name as it Appears on Card: _____

Type of Card:

___MasterCard ___Visa ___Discover ___American Express

Card Number:

☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiration Date: _____ (month/year) **Security Code**: _____ (last 3 digits on back)

I authorize Restore Behavioral Health to process the above credit card as "Signature on File" for after-hours appointments, deductibles/co-insurances/co-pays, and/or cancellation/no-show fees.
I understand this authorization will expire upon conclusion of care.

_____ _____

Cardholder's Signature Date

Restore Behavioral Health, PLLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Patient Name:	Date of Birth:
Address:	Telephone Number: ( )_____
City: _____ State: _____ Zip Code: _____	

I hereby authorize Restore Behavioral Health, PLLC to release and exchange written, oral or electronically transmitted protected health information indicated below on the above named individual to:

_____

Provider Name/Organization/Individual *(Physician/Pediatrician, Referring Doctor/Clinic, Family Member, School, etc.)*

_____

Address of Provider/Organization/Individual

Fax #: ( )_____

City: _____ State: _____ Zip Code: _____ Telephone #: ( )_____

Including information related to: ☐ Mental Health Treatment___ Substance Abuse Treatment___ Medical Treatment___ School ___
☐ Other: _____

For the following purpose: Physician or Health Care Facility Use___ Legal Use___ Personal Use___ Follow-up Care___
School/Vocational Placement___ Insurance Determination___ Continuity of Care___ Other (Specify)_____

Treatment date(s): _____ to _____

Expiration Date: _____
(Should Not Exceed 1 Year)

INFORMATON TO BE DISCLOSED:

Assessment	Treatment/Service	Other
__Psychiatric	__Treatment Plan/NFB Tx Plan	__Discharge Summary
__Psychological	__Treatment Progress	__Dates of service
__Psychological test reports	__Medication information	__Lab results
__Intake	__Psychiatry Notes	__Behavior and history of patient
__Other: Digital EEG, QEEG	__Progress Notes	__Complete copy of clinical record
		__Other: _____

☐ **HIV Documentation** _____ **(Must Initial)**

I understand that:

- **The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).**
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing.
- Revocation will not apply to information that has already been released in response to this authorization.
- Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.

_____ _____ _____ _____
(Signature of patient) (Date) (Signature of Parent or Legal Representative) (Date)

_____ _____
(Witness Signature) (Date)

(Patients 12 to 17 years of age must sign in addition to the Parent or Legal Representative)
(If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR OFFICE USE: Date received: _____ Date completed: _____
When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: Driver's License___ Picture ID___ Legal guardian___
Court appointed legal guardian___ Power of Attorney___ Executor of Estate___ Other:_____

_____
Person completing the request:

RBH PATIENT MEDICATION LIST

Patient Name: _____

Date: _____

Please list all prescription, over-the-counter, and as needed medications you are currently taking.

Name of Medication	Date Started	Dosage	How often is it taken? When is it taken? AM/PM	Reason for Taking	Prescribing Physician Name
1.)					
2.)					
3.)					
4.)					
5.)					
6.)					
7.)					
8.)					
9.)					
10.)					
11.)					
12.)					
13.)					
14.)					