

# 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?

If not, what is your legal name?

(Former Name)

Birth Date

Age

Sex

Yes  No

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)

# RBH NEURODEVELOPMENTAL HISTORY FORM

Intake Date: \_\_\_\_\_

For Child and Adolescent Intakes

Patient Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Patient Mother's name: \_\_\_\_\_ Patient Father's name: \_\_\_\_\_

## GESTATIONAL PERIOD: (Check all that Apply):

\_\_\_\_ Full-Term Pregnancy \_\_\_\_ No In Utero Complications \_\_\_\_ Pre-Term Pregnancy: \_\_\_\_ Weeks Gestation

Reason for Pre-Term Birth: \_\_\_\_\_

\_\_\_\_ Maternal Preeclampsia \_\_\_\_ In Utero Complications (Please Describe): \_\_\_\_\_

## BIRTH HISTORY: (Check all that Apply): \_\_\_\_ Birth History Unknown

\_\_\_\_ Vaginal Delivery \_\_\_\_ No Birth Complications \_\_\_\_ Normal Birth Weight: \_\_\_\_ lbs \_\_\_\_ Low Birth Weight: \_\_\_\_ lbs

\_\_\_\_ Forceps or Vacuum Assisted Delivery \_\_\_\_ Planned C-Section \_\_\_\_ Emergency C-Section: Reason - \_\_\_\_\_

\_\_\_\_ Suspected In Utero Exposure to Toxicity \_\_\_\_ IntraUterine Growth Retardation (IUGR)

\_\_\_\_ Fetal Distress \_\_\_\_ Umbilical Cord wrapped around neck \_\_\_\_ Possible Hypoxia (lack of oxygen)

\_\_\_\_ Impaired Apgar scores \_\_\_\_ NICU required: \_\_\_\_ days/weeks (circle one) \_\_\_\_ Neonatal Jaundice

\_\_\_\_ Neonatal Surgery Required: \_\_\_\_\_

\_\_\_\_ Other: \_\_\_\_\_

## DEVELOPMENTAL HISTORY: (Check all that Apply):

\_\_\_\_ Normative Development; All Developmental Milestones met within normal limits

\_\_\_\_ Delay in Talking/Language Milestone: Age began to talk: \_\_\_\_\_ Ongoing Difficulties w/Language

\_\_\_\_ History of Speech Therapy \_\_\_\_ Currently in Speech Therapy

\_\_\_\_ Articulation Difficulties \_\_\_\_ Stuttering \_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_ Delay in Fine or Gross Motor Skills \_\_\_\_ History of Physical Therapy \_\_\_\_ Current Physical Therapy

\_\_\_\_ History of Occupational Therapy \_\_\_\_ Current Occupational Therapy

\_\_\_\_ Delay in Toileting Age Toileting Attained: \_\_\_\_\_

\_\_\_\_ Delay in Adaptive Functioning (Grooming, Daily Living, Functional Communication) \_\_\_\_ Delayed Social Functioning

\_\_\_\_ Hx of ABA Therapy \_\_\_\_ Current ABA Therapy

\_\_\_\_ Delay in Sensory Integration Functioning (Sensitivity to Sounds, Textures, Visual Input)

\_\_\_\_ Other: \_\_\_\_\_

## MEDICAL HISTORY: (Check all that Apply):

\_\_\_\_ No History of Major Medical Difficulties; Child/Adolescent is in good health

\_\_\_\_ Positive History of Head Injury or Concussion: Dates: \_\_\_\_\_ Describe Injury & Treatment: \_\_\_\_\_

\_\_\_\_ Positive History of Seizure: Dates: \_\_\_\_\_ Describe Injury and Treatment: \_\_\_\_\_

\_\_\_\_ History of Involvement in Sports Related Injuries: \_\_\_\_\_

\_\_\_\_ History of Involvement in Major Motor Vehicle Accident: \_\_\_\_\_

\_\_\_\_ History of Neurological Evaluation: Neurologist: \_\_\_\_\_ Date of Eval: \_\_\_\_\_

Results of Eval: \_\_\_\_\_

\_\_\_\_ History of Chronic Ear Infections \_\_\_\_ History of Tubes in Ears \_\_\_\_ History of Loss of Consciousness: Describe: \_\_\_\_\_

\_\_\_\_ List any Medical Diagnoses/Conditions treated during childhood: \_\_\_\_\_

## PSYCHOLOGICAL/PSYCHIATRIC HISTORY (Check all that Apply):

\_\_\_\_ No prior psychological/psychiatric evaluation or treatment \_\_\_\_ Prior Testing Completed - Date: \_\_\_\_\_

\_\_\_\_ Prior treatment with psychotherapy: Dates: \_\_\_\_\_ \_\_\_\_ Currently in Therapy with External Provider

\_\_\_\_ Prior Hx of Inpatient Psych Treatment: \_\_\_\_\_

\_\_\_\_ Currently receiving medication from Pediatrician or Psychiatrist for Psychiatric diagnosis (Describe): \_\_\_\_\_



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.

#### **ACKNOWLEDGEMENT 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.

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\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
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:

- The right of access to medical, dental, psychological, and educational records of a minor;
- The right to consult with a physician, dentist, or psychologist of the minor;
- The right to be designated on the minor's records as a person to be notified in case of emergency; and,
- 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:

- Is on active duty with the armed services of the United States of America;
- 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,
- 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



### 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 arise 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

# 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)

**INFORMATION TO BE DISCLOSED:**

- |  |   |   |
|--|---|---|
| <u>Assessment</u><br><input type="checkbox"/> Psychiatric<br><input type="checkbox"/> Psychological<br><input type="checkbox"/> Psychological test reports<br><input type="checkbox"/> Intake<br><input type="checkbox"/> Other: Digital EEG, QEEG | <u>Treatment/Service</u><br><input type="checkbox"/> Treatment Plan/NFB Tx Plan<br><input type="checkbox"/> Treatment Progress<br><input type="checkbox"/> Medication information<br><input type="checkbox"/> Psychiatry Notes<br><input type="checkbox"/> Progress Notes | <u>Other</u><br><input type="checkbox"/> Discharge Summary<br><input type="checkbox"/> Dates of service<br><input type="checkbox"/> Lab results<br><input type="checkbox"/> Behavior and history of patient<br><input type="checkbox"/> Complete copy of clinical record<br><input type="checkbox"/> 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.)					





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 \$45 for Therapy Visits on Monday through Saturday. There is a 3 BUSINESS DAY cancellation policy for ALL TESTING appointments of \$75.00. 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

## 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 co-pays, co-insurance 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
      - \$45.00 for therapy, test results, neurofeedback, HBI; ( less than 24 hours)
      - \$75.00 for testing and QEEG appointments; **NEED 3 BUSINESS DAYS ADVANCE NOTICE**
    - 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: \_\_\_\_\_

## 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 insurance 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/co-insurance 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 (30 min.)	\$75	\$50	Psychological & Neuropsychological Testing:	\$135 / hr	N/A
Individual Psychotherapy (45 min.)	\$135	\$105	EEG Biomarker Testing (Fee-for-Service Only)	\$79	N/A
Family Psychotherapy (45-50 min)	\$150	\$125	Neurobehavioral Status Exam:	\$105	N/A
Group Psychotherapy (45-50 min)	\$60	\$45	Telehealth Therapy	\$60 - 30 min \$85 - 45 min	\$50 - 30 min \$75 - 45 min
Health and Behavior Assessments	\$130/hr	N/A	Health and Behavior Interventions	\$60 -30 min \$110 - 60 min	N/A
Deep States Therapy (FFS ONLY)	\$270	\$210			

**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