

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) _____



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.

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.

*\$25 Cancellation Fee - (Mon. – Fri) Therapy Appointments

*\$75 Cancellation Fee - All Testing Appointments

*\$40 Cancellation Fee - (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 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 voluntarily consent to treatment at Restore Behavioral Health with the knowledge of the above conditions.

Client Name

Client or Legal Guardian Signature

Date

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 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)
 - \$25.00 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: _____



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



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, \$25 for Therapy Visits on Monday through Friday and \$40 for Therapy Visits on Saturdays. 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)

INFORMATION TO BE DISCLOSED:

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

- ___ 39. Difficulties seeing options in situations
- ___ 40. Tendency to hold on to own opinion and not listen to others
- ___ 41. Tendency to get locked into a course of action, whether or not it is good
- ___ 42. Needing to have things done a certain way or you become very upset
- ___ 43. Others complain that you worry too much
- ___ 44. Tend to say no without first thinking about the question
- ___ 45. Tendency to predict fear
- ___ 46. Frequent feelings of sadness
- ___ 47. Moodiness
- ___ 48. Negativity
- ___ 49. Low energy
- ___ 50. Irritability
- ___ 51. Decreased interest in others
- ___ 52. Decreased interest in things that are usually fun or pleasurable
- ___ 53. Feelings of hopelessness about the future
- ___ 54. Feelings of helplessness or powerlessness
- ___ 55. Feeling dissatisfied or bored
- ___ 56. Excessive guilt
- ___ 57. Suicidal feelings
- ___ 58. Crying spells
- ___ 59. Lowered interest in things usually considered fun
- ___ 60. Sleep changes (too much or too little)
- ___ 61. Appetite changes (too much or too little)
- ___ 62. Chronic low self-esteem
- ___ 63. Negative sensitivity to smells/odors
- ___ 64. Frequent feelings of nervousness or anxiety
- ___ 65. Panic attacks
- ___ 66. Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)
- ___ 67. Periods of heart pounding, rapid heart rate or chest pain
- ___ 68. Periods of trouble breathing or feeling smothered
- ___ 69. Periods of feeling dizzy, faint or unsteady on your feet
- ___ 70. Periods of nausea or abdominal pain
- ___ 71. Periods of sweating, hot or cold flashes
- ___ 72. Tendency to predict the worst
- ___ 73. Fear of dying or doing something crazy
- ___ 74. Avoid places for fear of having an anxiety attack
- ___ 75. Conflict avoidance
- ___ 76. Excessive fear of being judged or scrutinized by others
- ___ 77. Persistent phobias
- ___ 78. Low motivation
- ___ 79. Excessive motivation
- ___ 80. Tics (motor or vocal)
- ___ 81. Poor handwriting
- ___ 82. Quick startle
- ___ 83. Tendency to freeze in anxiety provoking situations
- ___ 84. Lacks confidence in their abilities
- ___ 85. Seems shy or timid

- 86. Easily embarrassed
- 87. Sensitive to criticism
- 88. Bites fingernails or picks skin
- 89. Short fuse or periods of extreme irritability
- 90. Periods of rage with little provocation
- 91. Often misinterprets comments as negative when they are not
- 92. Irritability tends to build, then explodes, then recedes, often tired after a rage
- 93. Periods of spaciness or confusion
- 94. Periods of panic and/or fear for no specific reason
- 95. Visual or auditory changes, such as seeing shadows or hearing muffled sounds
- 96. Frequent periods of déjà vu (feelings of being somewhere you have never been)
- 97. Sensitivity or mild paranoia
- 98. Headaches or abdominal pain of uncertain origin
- 99. History of a head injury or family history of violence or explosiveness
- 100. Dark thoughts, may involve suicidal or homicidal thoughts
- 101. Periods of forgetfulness or memory problems

Brief Patient Health Questionnaire™ (PHQ-Brief)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name _____ Age _____ Sex: Female Male Today's Date _____

- | 1. Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems? | Not at all | Sever
al
days | More
than
half
the
days | Nearl
y
every
day |
|---|--------------------------|--------------------------|-------------------------------------|----------------------------|
| a. Little interest or pleasure in doing things | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Feeling down, depressed, or hopeless | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Trouble falling or staying asleep, or sleeping too much | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Feeling tired or having little energy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Poor appetite or overeating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Trouble concentrating on things, such as reading the newspaper or watching television | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Thoughts that you would be better off dead, or of hurting yourself in some way | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Questions about anxiety.

- | | | |
|--|--------------------------------|---------------------------------|
| a. In the <u>last 4 weeks</u> , have you had an anxiety attack — suddenly feeling fear or panic? | NO
<input type="checkbox"/> | YES
<input type="checkbox"/> |
|--|--------------------------------|---------------------------------|

If you checked "NO", go to question #3.

- | | | |
|--|--------------------------|--------------------------|
| b. Has this ever happened before? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do some of these attacks come <u>suddenly out of the blue</u> — that is, in situations where you don't expect to be nervous or uncomfortable? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do these attacks bother you a lot or are you worried about having another attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach? | <input type="checkbox"/> | <input type="checkbox"/> |

3. If you checked off any problems on this questionnaire so far, 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?

Not difficult
at all

Somewhat
difficult

Very
difficult

Extremely
difficult

4. In the last 4 weeks, how much have you been bothered by any of the following problems?
- | | Not
bothered | Bothered
a little | Bothered
a lot |
|---|--------------------------|--------------------------|--------------------------|
| a. Worrying about your health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your weight or how you look | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Little or no sexual desire or pleasure during sex | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The stress of taking care of children, parents, or other family members | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Stress at work outside of the home or at school | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Financial problems or worries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Having no one to turn to when you have a problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Something bad that happened <u>recently</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Thinking or dreaming about something terrible that happened to you <u>in the past</u> - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

5. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?
- | | NO | YES |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

6. What is the most stressful thing in your life right now? _____

7. Are you taking any medicine for anxiety, depression or stress?
- | | NO | YES |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.

- a. Which best describes your menstrual periods?

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Periods are unchanged | <input type="checkbox"/> No periods because pregnant or recently gave birth | <input type="checkbox"/> Periods have become irregular or changed in frequency, duration or amount | <input type="checkbox"/> No periods for at least a year | <input type="checkbox"/> Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive |
|--|---|--|---|---|

- | | NO
(or does not apply) | YES |
|--|---------------------------|--------------------------|
| a. During the week before your period starts, do you have a <u>serious</u> problem with your mood - like depression, anxiety, irritability, anger or mood swings | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If YES: Do these problems go away by the end of your period? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you given birth within the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you had a miscarriage within the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are you having difficulty getting pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |