# BAY AREA PSYCHIATRY GROUP

ROBERT N EARLE MD, PA
Lynda Barker MSN, RN, PMHNP
Paige Thomson MA, LPC-S
Laura Hicks LPC, LMFT

Stephen Lippold PhD
Myra Johnson LCSW, CMC
Shannon Wenger MA, LPC
Lisa Layne LCSW-S

## Patient Intake:

Date: _____ Gender: M/ F Referred by: _____

Patient Name: _____ DOB_____ SS#_____

Patient Address_____

Mailing Address:_____
(if different) City State Zip Code

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email Address: _____

Emergency Contact/ relationship: _____Phone:_____

Presenting Problems: _____

**Please circle all that apply:**

Depressed Mood Anxiety Grief or Loss Panic Attacks Substance Abuse Sleep Disturbance

Cutting/Self-Mutilation Hallucinations Suicidal /Homicidal Thoughts Recent Hospitalization

Problems with: Relationships Work School Anger Behavior Parenting Issues

HX of Substance Abuse: Yes/No HX Suicide Attempts: Yes/No Previous psychiatric hospitalizations: Yes/No

**Medications you are currently taking:**

_____

_____

Allergies: _____

**Pharmacy:** _____ **Phone:** _____

Members of your household and their relationship to you:

_____

_____

**I have received a copy of the Notice of Privacy Practice for the office**

Signature: _____ Date: _____

**Bay Area Psychiatry Group**
1002 Gemini, Suite 205 Houston, Texas 77058
Phone: 281-218-8181 Fax: 281-218-7676

## Insurance Information

**Primary Insurance:** _____ Policy Holder: _____

Insured ID #: _____ Group #: _____

Insured Social Security #: _____ Insured DOB: _____

Insurance Company Phone #: _____ Relationship to Insured: _____

**Secondary Insurance:** _____ Policy Holder: _____

Insured ID#: _____ Group #: _____

Insured Social Security #: _____ Insured DOB: _____

Insurance Company Phone #: _____ Relationship to Insured: _____

**I, the undersigned, authorize the release of necessary information for the benefit payment. I also authorize payment of insurance benefits otherwise payable to me directly to the healthcare provide. I understand that I am responsible for copayments, deductible, and other charges whether or not paid by insurance. I authorize a copy of this release to be used in place of the original.**

**Signature:** _____ **Date:** _____

## Credit Card Information Form

Name on Card: _____ Phone #: _____

Card Type: _____ Account Number: _____

Expiration Date: _____ CVV Code: _____ Billing Zip Code: _____

Patient Name: _____

Amount of credit charge: _____

I agree to allow BAPG to retain a copy of my credit card on file to be used in accordance the financial policies of which I was made aware of as a new patient to the practice.

BAPG will notify you of any charges incurred due to missed appointments via email on the service day in question.

**Signature:** _____ **Date:** _____

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## Practice Policies and Procedures & Informed Consent

Welcome to Bay Area Psychiatry Group (BAPG). We are committed to providing you with quality psychiatric services and look forward to working with you. Please read the following policies that constitute the treatment agreement between you and BAPG and initial each section. Your signature at the bottom of the page indicates that you have read and agree to these policies. If you have any questions, please speak with a member of our staff before signing this form.

_____ **Office Hours:** Our main office hours are Monday through Thursday 8:30 am to 5:30 pm and Friday 8:30 am to 3:00 pm. Any message left on the recorder before 3 pm will be returned the same business day. BAPG is comprised of numerous providers with varying schedules, some of which offer extended day appointments. Our staff is happy to work with you on the varied hours. If you have an emergency situation, please call 911 or go to the nearest emergency room.

_____**Appointments:** Appointments are scheduled by calling our office. Patients are able to relay messages to staff through our web site regarding appointment requests and changes but please note appointments are not confirmed unless you speak with a staff member from BAPG directly. Having 3 or more no-shows or cancellation of appointments may result in termination of treatment. You may be asked to reschedule if you are more than 15 minutes late for your appointment.

_____**Cancellations and No-Shows:** We require a 24 hour notice to cancel or reschedule an appointment. Same day cancellations or missed appointments will be charged an administrative fee of $30.00 for medication appointments, $55.00 for psychotherapy during business hours and $110.00 for psychotherapy after- hour appointments. This fee is not covered by insurance. If you fail to show up for your initial appointment or cancel/reschedule less than 24 hours in advance, you may not be able to reschedule your appointment. Additionally, BAPG will maintain your credit card on file for after-hour appointments.

As a courtesy, we make reminder calls or send automated emails prior to your scheduled appointments. We are not responsible for appointments missed due to incorrect contact information or non-receipt of a voicemail/email. **It is your responsibility to keep your scheduled appointments.**

_____**Payment of Services:** It is our policy to collect payment prior to your session. You are responsible for all co-pays, co-insurances, and deductibles. We accept cash, check, Visa, MasterCard, debit card and money orders. If a check is returned for insufficient funds you will be charged $30 for returned check fee.



_____**Insurance:** We require a copy of your insurance card and photo ID upon signing in. If we are in-network with your insurance plan, we will file a claim on your behalf. Coverage varies widely from plan to plan and the exact amount your insurance company will cover cannot always be determined accurately until the claim is processed. You are responsible for any charges that are not covered by your

insurance carrier. If your insurance does not pay within 60 days, you will be responsible for payment. I authorize the release of any information necessary to process claims to my insurance plan and/or to the insurance plan of individuals for which I am legally responsible.

Please provide our office with any changes in your insurance 72 hours before your appointment or the visit will be self-pay or rescheduled. Submit new information by calling our office, faxing, or visit our website at **www.bapsych.net**. New insurance without verification will require the patient to pay for the service in full prior to the appointment.

If you do not have insurance or your insurance does not cover these services, you will be considered "self-pay" and payment is due in full at the time of service.

_____**Completion of Forms:** Due to the time involved for our providers and staff, it is necessary to charge for all forms and letters. This is to be paid in advance and is not billed to your insurance. The cost for drafting letters and completing forms is $30.00.

_____ **Emergency Treatment:** I agree to contact my provider or 911 in the event that I feel suicidal or violent in order to take the steps necessary to protect the safety of others and myself.

_____ **Court Testimony:** If you have your provider subpoenaed, you will be billed at the self-pay rate for each hour your provider is required to be available. Such fees are payable at the time services are provided. Unpaid balances for these services must be paid before services can continue.

_____**Record Request:** If your records are requested, they will be sent to a professional at no charge. If your records are subpoenaed, you will be charged $25. Payment is due before records will be released. A release of information must be signed before any patient information, written or verbal, will be released.

I have read this agreement and understand that I am responsible for payment of the fee as described above. I acknowledge having received written descriptions of the Notice of Privacy Practices. I understand that my records will be accessible to the associates and staff of BAPG, who will be held responsible for maintaining strict confidentiality unless otherwise instructed or authorized.

**By signing below, I give my consent for treatment within Bay Area Psychiatry Group.**

**Patient/Guardian Printed Name(s):** _____

**Patient/Guardian Signature & Date:** _____ **Date:** _____

**Witness:** _____

# Bay Area Psychiatry Group

## PATIENT BILL OF RIGHTS

**Patient Rights**
I have the right to efficient and effective care individualized to my needs. My treatment provider will work with me to develop a treatment plan best suited for me. We will use this plan to help us deal with my problems as quickly and effectively as possible. I have the right to refuse treatment or discontinue treatment.

I have the right to be treated with dignity and respect. I will be treated with respect at all times. I will report any misconduct by my treatment provider including social invitations, suggestive remarks or unwanted touching to the appropriate state agency. I will report any complaints regarding the clerical staff to my doctor/therapist or office manager.

My treatment provider will make every effort to meet with me at our scheduled appointment time. If my treatment provider is late, he or she will extend our session, if I am willing, or we will make other arrangements by mutual agreement.

I have the right to privacy and confidentiality. All records and communications about me will be treated confidentially in compliance with applicable state and federal laws. These laws may obligate my treatment provider to report suspected abuse, neglect, or domestic violence and those who pose a danger to themselves or others.

**Patient Responsibilities**
Scheduled appointments are commitments. I will make every effort to be on time for my appointments. If I am late for my appointment, I understand that time will be lost from my session. If I miss an appointment and do not notify my provider at least 24 hours in advance, I understand I may be charged a missed appointment fee.

I am responsible to pay for services received. I am aware my insurance plan typically requires me to pay a co-pay or percentage of my treatment fee at the time services are provided. My insurance plan may also have a deductible that is my responsibility. Additionally, certain services may be limited and/or not covered at all by my insurance plan. I understand I am financially responsible for all co-pays, co-insurance amounts, deductibles and all services not covered by my insurance plan. My provider, the office staff, and my insurance plan's representative will help me determine what services my plan covers.
My health is my responsibility. I will contact my treatment provider for any serious situation that arises, even if after normal office hours. I will work with my provider to achieve my treatment goals and will advise my provider of any changes in my condition.

**I have read or had read to me the above list of Rights and Responsibilities.**
**I understand them and agree to them.**

Patient Name:_____ DOB:_____ Date:_____

Signature of Patient/Guardian:_____ Relationship: _____

# Bay Area Psychiatry Group

## CONSENT FOR COMMUNICATION

Family members and friends occasionally become involved in our patient's care. For example, your spouse calls to confirm your appointment time, or a friend, who helps you, calls because they are concerned about you. You have a right to request that we restrict how protected health information about you is used or disclosed.

**If you have anyone that you would allow us to communicate with, please list them below**. Due to privacy regulations, we cannot speak to anyone but the patient unless we have a court order, your written permission, or under circumstances described next.

**I give Bay Area Psychiatry Group my permission to speak with the following individuals regarding my care: (If you prefer that we speak with no one, please write "NO ONE" across the lines).**

**Please identify relationship of anyone authorized to discuss your care:**

_____
_____
_____
_____
_____

I understand that I have the right to revoke this authorization **in writing** at any time. I request that my confidential information be handled in the following manner and authorize Bay Area Psychiatric Group staff to disclose information only to those individuals listed above, and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

Patient Name: _____

Patient Signature:_____ Date: _____

Signature of Legal Guardian for minor: _____ Date: _____

## Bay Area Psychiatry Group

## Limits of Confidentiality

Contents of psychiatric and psychotherapy sessions are considered to be confidential and can usually be shared with another party only with written consent of the client or their legal guardian, or with a court order. Noted exceptions are as follows:

**Duty to Warn and Protect:**

When a client discloses the intention to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing or has recently abused a child or vulnerable adult, or either party is in danger of abuse, the mental health professional is required to report the information to the appropriate social service and/or legal authorities.

**Parents and Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

**Insurance Providers**

Insurance companies and other third party payers are given the requested information necessary to facilitate payment for services rendered.

**I agree to the above limits of confidentiality and understand their meanings and ramifications.**

_____

Client Signature (Parent/Guardian if client a minor)

_____

Date

## Bay Area Psychiatry Group

## Medication Policies

**Robert N Earle MD** **Lynda Barker MSN, RN, PMHNP**

We ask all new patients to review the medication policies and acknowledge receipt through signature at the bottom of the page, even if their treatment is psychotherapy only. This ensures that any patient who may be referred to a prescribing provider at a later date has had the opportunity to be informed of the policies and procedures regarding medication management by this office.

_____ **Medication Policy:** Enough medication will be prescribed to last until your following appointment. Should a patient need a refill prior to the next appointment, the office should be given 48 hours to process the request. Any refill request phoned in on a Friday or weekend will be processed on the next business day. We reserve the right to deny medication refills when appointments are not kept.

_____ **Controlled Substance Notice:** For management of select diagnoses, at times it is necessary to be treated with medications with high-abuse potential. BAPG participates in the Texas Department of Public Safety prescription data program. This program tracks every controlled prescription written and filled in Texas by every physician, pharmacy, and patient, regardless of whether the prescription is purchased with cash, credit, or insurance. BAPG providers may access your prescription data if there is any suspicion of abuse, diversion, or overuse of your prescription. Diversion of controlled medications is a crime and is taken seriously by BAPG. This includes doctor shopping, pharmacy hopping, abuse, overuse, and/or sharing of your scheduled II medications with others.

_____ **Controlled Substance Refills:** Stimulant medications such as Ritalin, Vyvanse, Adderall, etc., are issued by your provider on a monthly basis. These medications are highly regulated. Prescriptions for this class of medications must be picked up at the office. In select instances, BAPG is willing to mail a script providing a self-addressed stamped envelope is made available to the office ahead of time. Should the prescription for a controlled substance or the medication itself be lost, the prescription may not be replaced until the following month.

_____ **Female patients**: If taking medications I agree to notify my provider in the event that I am planning to become pregnant or I become pregnant so that I ma discuss the risks/ benefits of medications.

Patient/Guardian Printed Name(s) _____Date: _____

Patient/Guardian Signature: _____ Date: _____

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Patient Name:_____

**Parental Consent for Minors**

I_____, being the legal parent/guardian of _____ hereby give my consent for my son/daughter to receive the counseling/psychiatric services of Bay Area Psychiatry Group (BAPG). I further agree to allow _____ to continue in treatment until I notify BAPG of any other changes or plans to discontinue, or until the BAPG provider determines that treatment is no longer necessary.

I understand that the information my son/daughter shares with the counselor is confidential and can be shared with me only at the counselor's discretion.

_____

Signature of Parent or Guardian

_____

Date

# Notice of Privacy Practices

This notice describes how private health information (PHI) about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

**Uses and Disclosures**

**Treatment:** Our staff members may disclose your PHI to other health professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

**Payment:** Your PHI may be used to seek payment from your insurance plan or from other sources such as credit card companies that you may use to pay for service.

**Health Care Operations**: Your PHI may be used as necessary to support the day-to day activities such as in the case of students working with BAPG

**Law Enforcement:** Your health information may be disclosed to Law Enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with mandated reporting.

**Public Health Reporting**: We may disclose your PHI to public health agencies as required by law.

**Other Uses and Disclosures:** Disclosure of your PHI or its use for any purpose other than those listed above requires your written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. Your decision to revoke does not apply to disclosure of information that occurred prior to the revocation.

**Additional Uses of Information:** Your PHI may be used to send you information on the treatment and management of your medical condition that you may find of some interest.

**Individual Rights**

You have certain right under Federal Privacy Standards. These include:

The right to request restriction on the use and disclosure of your PHI
The right to receive confidential communications concerning your medical condition and treatment.
The right to inspect and copy your protected PHI. (Pt access is limited with regard to psychotherapy notes)
The right to amend or submit corrections to your PHI.
The right to receive an accounting of how and to whom your PHI has been disclosed.
The right to receive a printed copy of this notice.

BAPG is required to maintain the privacy of your PHI and to provide you with this notice. We are also required to abide by the privacy policies and practices that are outlined in this notice.

**Right to Revise Privacy Practices**
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by changes in Federal or State laws. Whatever the reason for the revisions, we will provide you a copy of the revised notice.

**Requests to Inspect PHI:**
As permitted by law, we require that your request to inspect or copy your PHI be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy officer.

If you would like to submit a comment or complaint about our privacy practices please send a letter addressing your concerns to:

**Bay Area Psychiatry Group**
**ATTN: Privacy Officer**
**Stephen Lippold PhD**
**1002 Gemini suite 205**
**Houston, Texas 77058**

If you believe your rights have been violated, you should call the matter to our attention by sending a letter describing your concern to the address listed above.