

PSYCHIATRY OF TEXAS

NEW CLIENT INFORMATION - Adult

Date: _____ Account # _____

Name: _____

Male/Female _____ Date of Birth: _____ SSN: _____

Race: _____ Preferred language: _____

Married: ___ Single: ___ Divorced: ___ Separated: ___ Widowed: ___

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Home ___ Cell ___ Work ___

Is it okay to leave a voice mail message? Y/N

Email Address: _____ Secondary Phone: _____

Type of Insurance: Primary : _____ Secondary: _____

Is client their own legal guardian? Y/N

If not, Name of Legal Guardian: _____

Phone: _____

Referred by: _____

Do you have any family members seeing somebody here? Y/N

If yes, how are they related? _____

If yes, who are they seeing? Doctor? _____

Therapist? _____

Emergency contact: _____ Phone #: _____

Patient's relationship to emergency contact: _____

Employee initials: _____

ASSESSMENT QUESTIONNAIRE

Please check any of the statements that apply to you today. This information will be shared with your nurse or provider, if needed, so we can better serve you.

_____ I am having thoughts about suicide today.

_____ I have had suicidal thoughts in the last two months.

_____ I have attempted suicide in the past.

_____ I have a suicide plan.

_____ Even though I think about suicide, I would not act on these thoughts.

_____ I feel that I can keep myself safe until I can get help with my problems.

_____ I am concerned that I may not be safe when I leave here today.

_____ I hear voices that tell me to hurt myself or other people.

_____ I have thoughts about physically harming or killing other people.

_____ I cannot keep myself from physically harming or killing others.

_____ I feel like I am in control of my actions and will not physically harm or kill anyone.

_____ I want to see a **doctor** so I can get on a medication to help me.

Previous Diagnosis (depression, Bipolar, PTSD, etc.): _____

Have you ever had previous psychiatric treatment in a hospital? _____

Have you used drugs or alcohol in the last three months? _____

Do you currently have severe sleep problems? _____

Please tell us what you want help with: _____

Print name of client

Signature of client/guardian

Date: _____

Chart: _____

CLIENT’S INFORMED CONSENT

I have voluntarily chosen to receive treatment services by Psychiatry of Texas. I understand that I may terminate services at any time.

I understand that psychotherapy is a cooperative effort between me and my provider and I will work with my provider in a cooperative manner to resolve my issues.

I understand that during the course of my treatment material may be discussed which may be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will remain confidential and will only be released with a signed consent form in accordance with state laws regarding confidentiality.

I understand that my records may be released in accordance with state and local laws in cases in which a danger to self or others exists.

I understand that I may be contacted by Psychiatry of Texas to ensure continuity and quality of my treatment and/or after the completion of, to assess the outcome of treatment. I have read and understand the basic rights of individuals as seen at Psychiatry of Texas. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision on whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that my provider, insurance representatives, and my primary care physician may exchange any and all information pertaining to my services, including retrieval of my medication history, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after discharge of treatment.

Client Acknowledgment and Consent to Privacy Notice

I have received an orientation to the clinic, which has explained the policies and procedures and I consent to Psychiatry of Texas privacy notice, a copy of which has also been made available to me.

I have read and understand the above.

Print name of client

Signature of client/guardian

Date: _____

INSURANCE

Primary Insurance:

Name of insurance company: _____

Cardholder's Name: _____ Patient's relationship to cardholder: _____

Gender of cardholder: M/F Cardholder's date of birth: _____

Certificate (ID) #: _____ Group #: _____

Cardholder's social security #: _____ - _____ - _____ Place of employment: _____

Secondary Insurance:

Name of insurance company: _____

Cardholder's Name: _____ Patient's relationship to cardholder: _____

Gender of cardholder: M/F Cardholder's date of birth: _____

Certificate (ID) #: _____ Group #: _____

Cardholder's social security #: _____ - _____ - _____ Place of employment: _____

You are required to provide Psychiatry of Texas with any changes to your insurance coverage as they occur. If this is not provided, you will be financially responsible for the services that were provided to you. In the event that your insurance company pays you directly, you are responsible to reimburse Psychiatry of Texas for the amount that your insurance company pays you. All payments made to Psychiatry of Texas must be by cash or check.

I understand that this will become a part of my service record; information accumulated in the record may be confidentially reviewed by the accrediting agency for Psychiatry of Texas. I authorize to Psychiatry of Texas to file an insurance claim and receive the payment for services rendered on my behalf. Some insurance coverage requires co-payment and/or a deductible portion, which is due at the time of service.

Print name of client

Signature of client/guardian

Date: _____

CLIENT RIGHTS AND RESPONSIBILITIES

Client Rights Policy: The policy of Psychiatry of Texas is that all clients of the clinic will receive treatment subject to the following protection:

1. Each Client has the right to participate in the development of his/her treatment/service plan.
2. Services are made available to all Harris County residents on an equal basis.
3. Each Client has the right to assume that all treatment information will be held in confidence and will not be released to anyone unless one of the following situations exists:
 - a. Written request is made by a Client to release portions of file information.
 - b. That a court order requires submission of certain file materials.
 - c. That, in the opinion of the professional staff members of the clinic, a life-threatening situation exists.
4. Each Client of Psychiatry of Texas has the right to be fully informed about any risks that might be entailed in treatment or as the result of research studies.
5. Each Client of Psychiatry of Texas has the right to expect treatment with dignity and respect and without unnecessary invasion of privacy.
6. Each Client has the right to refuse treatment.
7. Each Client has the right to treatment with as little delay as possible.
8. Only information that is needed to assist Psychiatry of Texas' professional staff and their treatment process will be obtained from a client/guardian.
9. Each Client has the right to be treated in the least restrictive setting possible.
10. Each Client has the right to express his/her opinion concerning the services delivered at Psychiatry of Texas .
11. Clients of Psychiatry of Texas, and their guardians, have the right to appeal any policy, procedure, or action of Psychiatry of Texas in order to adequately protect the consumer's rights.
12. I have voluntarily chosen to receive treatment services by Psychiatry of Texas . I understand that I may terminate services at any time.

Procedure:

- a. First, the client/guardian should attempt resolution with their primary staff.
- b. If the issue is not resolved within fourteen days, written statements from the client/guardian and the staff person will be submitted to the staff person's immediate supervisor.

Client Responsibilities: I understand that in addition to having the rights listed above, I also agree to abide by the following responsibilities. I understand that failure to do so can result in my discharge from services.

1. I will take my medications as prescribed by the doctor to the best of my ability.
2. I will attend all scheduled appointments with my providers. If I cannot attend, I will call 24 hours in advance to cancel.
3. I will attempt to fulfill the goals I have set in my service plan to the best of my ability or, notify my provider if I feel the goal is no longer appropriate.
4. I will treat the staff respectfully and in the same manner that I would like to be treated.
5. I will refrain from abusing drugs and alcohol to the best of my ability.
6. I will contact my provider on a regular basis.
7. I understand that it will be necessary for me to sign documents in order to continue to receive services with Psychiatry of Texas

Print name of client

Signature of client/guardian

Date: _____

PSYCHIATRIC ADVANCE DIRECTIVE NOTIFICATION FORM

Do you have a Psychiatric Advance Directive Form or a Durable Power of Attorney for Medical Care Form?

Yes

No

If yes, do you wish to provide a copy to Psychiatry of Texas?

Yes

No

Copy provided to intake person?

Yes

No

PRIMARY CARE PHYSICIAN FORM

NAME OF PHYSICIAN: _____

PHONE NUMBER: _____

_____ I want you to contact my Primary Care Physician

_____ I do not want my Primary Care Physician contacted

_____ I do not have a Primary Care Physician

Print name of client

Signature of client/guardian

Date: _____