



**BORIS RUBASHKIN, MD**  
**DONNA EDWARDS, RN, MSN, PMH- NP**  
**BERNADATTE WILLIAMS, PMH-NP**

9525 Katy Freeway, Suite 312  
Houston, Texas 77024  
Phone (713) 463- 9449  
Fax (713) 463- 7181  
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Welcome!

Thank you for your interest in pursuing psychological services in this office. We will be glad to make ourselves available at any time to respond to your questions, concerns and comments by phone, electronic mail, fax and post.

Please take time to fill out this packet as thoroughly as possible. All information given will help us in evaluating you and in developing an appropriate treatment plan for you. In addition, we have attached the Notice of Privacy Practices for your perusal. We very much regret that the new law known as HIPAA (Health Insurance Portability & Accountability Act of 1996) requires that this packet be so lengthy. The intent of HIPAA is to guarantee the security of your healthcare information in this office, as in any healthcare provider's office.

Once again, thank you for your patience and efforts in completing these materials. We look forward to establishing a good relationship with you.

Sincerely,

BORIS RUBASHKIN, MD and Associates



9525 Katy Freeway, Suite 312  
Houston, Texas 77024  
Phone (713) 395-1555  
Fax (713) 395-1429

BORIS RUBASHKIN, MD  
DONNA EDWARDS, RN, MSN, PMH- NP  
BERNADETTE WILLIAMS, PMH-NP

### CONFIDENTIAL INFORMATION SHEET

This information is to help us better understand you and your situation. Please fill it out as completely as you can. All information will be held in strict confidence.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### **CLIENT INFORMATION:**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Sex: \_\_\_\_ M \_\_\_\_ F Marital Status: \_\_\_\_\_ E-mail: \_\_\_\_\_

Referred by: \_\_\_\_\_

#### **INSURANCE INFORMATION:**

Insurance Carrier: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Insured's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### **RESPONSIBLE PARTY INFORMATION:**

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Relationship to client: \_\_\_\_ Self \_\_\_\_ Spouse \_\_\_\_ Child \_\_\_\_ Other (please indicate): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

1. I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with the Accounting Department.
2. **AUTHORIZATION FOR RELEASE OF INFORMATION:** we hereby authorize the release of any information regarding my/my child's condition or treatment to insurance company.
3. **AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER:** we hereby authorize the payment of insurance benefits from my insurance company to my provider.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
(client or parent if client is a minor)

(OVER)

**Primary Doctor Information:**

Full Name of Current Primary Doctor: \_\_\_\_\_

Office Address of Primary Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

**Treatment History:**

List prior professional help received to address current concern:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

List all medication and drug allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all other allergies e.g. milk, chemicals, dust, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications**

List all medications prescribed and taken for the last 12 months:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Policies**

You will be charged for canceled appointments unless notice is received at least **24 hours** prior to the appointment time so that the time may be scheduled for another client. **Payment is expected at the time of each visit unless prior arrangements have been made.**

I understand and accept the policies concerning both the cancellations of appointments and payment for services. We will be responsible for the agreed upon payment due of \_\_\_\_\_ per session.

X \_\_\_\_\_ Date: \_\_\_\_\_  
(Client or Responsible party)

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## **NEW POLICY FOR REFILL ON CONTROLLED SUBSTANCE MEDICATIONS**

Because of the rising administrative cost for the issuance of Controlled Substance Schedule II Medication, we are implementing the following new procedure:

Patients who are stable on this medication do not have to come to our office every month to have their prescription refills. For your monthly refill, you can call the prescription line (713) 464 – 2595 and the office staff will call you if it is ready to pick up. Please leave your name, date of birth, medication you are requesting, contact # and address. **THERE WILL BE a \$10.00 ADMINISTRATIVE FEE FOR THIS SERVICE.** However, be advised that you are still required to see your provider **once every three months**. Your request will be denied if you don't schedule an appointment on the third month.

Thank you,

Boris Rubashkin, MD  
Donna Edwards, PMH-NP  
Bernadette Williams, PMH-NP

(This does not pertain to Medicare and Medicaid patients)

**The signature below confirms that the information has been read and understood.**

I, \_\_\_\_\_, **accept the policies listed above.**

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**Client's Signature**

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**Date**

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## GENERAL INFORMATION AND PROCEDURES

This form provides information about our services, procedures involved, and your authorized consent to treatment.

**Length of Session:** Initial Evaluation may last from 30 min to 45 min. On the other hand, follow-up treatment and medication management last about 10- 15 min.

**Cancellations:** Your appointment time is reserved for you and is taken seriously. **Except for emergencies, cancellations must be made 24 hours in advance to avoid being charged.** A 24 hour answering service, available seven days a week, is provided for your convenience at (713) 463- 9449.

**Fee Structure:** *The client is financially responsible for payment of fees, which will be collected at the time of service.* The client will also be responsible for any portion of fees not reimbursed or covered by health insurance. Additional cost may be incurred for use of assessment instruments. In the event of an accrued balance, the client and therapist can negotiate a payment schedule.

**Confidentiality:** Information shared is held in strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony requires by a judge, personal danger to self or an identifiable victim); information provided to parents if the client is a minor; and consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing identity. Release of information to another professional may be done only with your written consent.

**Client Privacy:** Recent laws have been enacted for client privacy. It is important to know that emails and mobile phone conversations are not secure or guaranteed of privacy because they can be potentially intercepted. Therefore, by signing this document you understand that if we have correspondence by email or mobile phone, there is a potential for confidentiality to be compromised.

**Treatment Approach:** To get the most out of this service, it is important to assume responsibility for your experience. The psychiatrist and or nurse practitioners can only help you based on the information you provide. If you are like most people, you probably have some sensitive issues you are not comfortable discussing with others. Those are usually the things you must need to talk about with the doctor. Depending on the circumstances, you may be asked to include some family members in your treatment. All medications prescribed should be taken as directed. Follow up appointments will depend on doctor's discretion.

**Prescription and Refills:** Prescription will be given to you at the time of visit. Additional refills will be given depending on the discretion of the doctor. When needed, refill request will be honored via fax or prescription voicemail line. **Any additional refills will not be issued, if patient cancelled or did not show for his/her appointment.** Our prescription fax line is (713) 463- 7181. Prescription VoiceMail is 713- 464- 2595.

The signature below confirms that the information has been read and understood. I, \_\_\_\_\_, accept the policies listed above. We hereby give fully informed consent to Dr. Rubashkin and or any of his associates, to enter into the psychological treatment process.

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Client's Signature

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Date

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

Behavioral Health Consultants  
9525 Katy Freeway, Suite 312  
Houston, Texas 77024  
Phone: (713) 463- 9449  
Fax: (713) 463- 7181

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: (877) 696-6775

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.  
I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

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## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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## BHC's No Show Pre-Authorized Charge Form

I authorize BHC-Behavioral Health Consultants, Inc. to keep my signature on file and to charge my Credit Card listed below for:

- The one time amount of \$ **140.00** in the event that patient fails to cancel their scheduled appointment 24 hours prior.

I understand that this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Customer Name: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Card Type:     Visa     MasterCard     Discover     American Express

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_                      Card Verification Number: \_\_\_\_\_

Cardholder Signature: X \_\_\_\_\_                      Date: \_\_\_\_\_

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### USE OF PRE-AUTHORIZED CHARGE FORMS

This form is a pre-authorization to charge credit card payments to your customers. You must still complete the actual credit card charges, including getting an authorization for each transaction.

The information on this form is to be used to fill out your charge slips, as is authorized by the cardholder for payment of future or ongoing visits.

1. The name of the service provider-your practice or business (as it appears on your card imprinter) must be filled in the top line.
2. The cardholder must choose one of the three payment schedules indicated by each of the three boxes:
  - i) Charges not paid by insurance, not to exceed a designated amount, for either the current visit, or for all visits within a year.
  - ii) Recurring charges of a specific amount, to be charged on a scheduled basis between two designated dates.
  - iii) A total fee, of a designated amount to be charged to the customer's card one time.
3. Personal information must be completed by the provider, stating the customer's name, cardholder's name, card type, account number and expiration date. Please be careful to note that the cardholder's card expiration date does not extend beyond the "ending date" for any recurring charges.
4. The cardholder must sign and date the form at the bottom.
5. The cardholder receives the top copy, and the bottom two copies are retained by the service provider. (If there is any discrepancy regarding the charges, the provider has the second copy to supply to the cardholder's bank.)
6. The form is valid for use for one year, or until the cardholder cancels authorization through written notice to the service provider.